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FEDERAL ROLE IN ADDRESSING THE TRAGEDY OF YOUTH SUICIDE

HEARING

BEFORE THE

SUBCOMMITTEE ON JUVENILE JUSTICE

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

ADEQUACY OF CURRENT FEDERAL RESEARCH AND PREVENTION EFFORTS AND THE ROLE OF THE OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION IN YOUTH SUICIDES

APRIL 30, 1985

Serial No. J-99-21

Printed for the use of the Committee on the Judiciary

U.S. GOVERNMENT PRINTING OFFICE
50-321 O WASHINGTON : 1985

S521-6

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FEDERAL ROLE IN ADDRESSING THE TRAGEDY OF YOUTH SUICIDE

TUESDAY, APRIL 30, 1985

U.S. SENATE,
SUBCOMMITTEE ON JUVENILE JUSTICE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The subcommittee met at 10:05 a.m., in room 226, Dirksen Senate Office Building, Hon. Jeremiah Denton presiding.

Present: Senators Specter, Simon, McConnell, and Metzenbaum.

Staff present: Neal S. Manne, chief counsel; Michael Russell, counsel; Tracy McGee, chief clerk; Vic Maddox, office of Senator McConnell; Rick Holcomb, office of Senator Denton; Laurie Westley, office of Senator Simon; Steve Ross, office of Senator Metzenbaum.

OPENING STATEMENT OF HON. JEREMIAH DENTON, A U.S. SENATOR FROM THE STATE OF ALABAMA

Senator DENTON. This hearing will come to order.

Good morning, ladies and gentlemen.

Senator Specter, the distinguished chairman of the Subcommittee on Juvenile Justice, has been delayed unavoidably this morning. He has asked, therefore, that I call the hearing to order in his absence.

I will make some brief opening remarks and then recognize other members, and I want to welcome at this time Mr. Simon, the distinguished Senator from Illinois. I will recognize other members of the subcommittee for their opening statements as those members arrive.

I would like to commend Senator Specter for his leadership in calling attention to the nationwide tragedy of youth suicide. Today's hearing, as well as the hearings conducted during the 98th Congress, forcibly addresses the phenomenon of children taking their own lives.

American children, adolescents, and young adults are killing themselves in ever-increasing numbers. The rate of suicide has increased more than threefold in the last 20 years and is still continuing to rise. In my own home State of Alabama, the rate of suicide has increased 122 percent during the same time period. This year alone, more than 5,000 young Americans can be expected to take their own lives.

Suicide now trails only accidents and homicides as the leading cause of death for people between the ages of 15 and 24. Even younger children experience problems which lead them to commit suicide. According to a report prepared by the National Center for Health Statistics, during a 13-year period ending in 1978, there were almost 2,000 documented cases of suicide among children under the age of 14.

In Alabama, according to information provided by the Alabama Department of Public Health, bureau of vital statistics, 256 children took their own lives during a 10-year period ending in 1983. Preliminary figures from the bureau estimate that 27 young Alabamians committed suicide in 1984. One of those tragic deaths involved a young student at the University of Alabama, Nix Handley, who shot himself on June 23, 1984. In a letter to me, dated March 20, 1985, Nix's parents detailed the agony which they suffered as a result of their son's death.

Without objection, I will place a copy of the letter in the hearing record at the conclusion of my statement.

The statistics to which I have alluded unfortunately represent only the tip of the iceberg. Some experts estimate that the actual number of suicides among young people is at least four times greater than is reported. Recent studies indicate that more than 2 million high school students attempted suicide last year.

Youth suicide is a phenomenon that is so perplexing, contradictory, frightening and troubling that our Nation avoids addressing it. As individuals and as a nation, we refuse to believe that young people emerging from childhood can feel the degree of sadness, hopelessness and despair that leads to suicide.

Inaction and walls of silence serve only as barriers to solving the problem. As a caring Nation concerning about the future of our young people, we must try to help. The children we have already lost to suicide include some of the best and brightest of their generation and the erstwhile hope for our future. Youth suicide is a problem of nationwide scope and can only be solved through the combined efforts of individuals, families, communities, organizations and Government to educate our society about what can be done.

We have not identified the precise cause of youth suicide but in raising seven children, helping raise eight grandchildren, and by meeting with children in discussion groups and teams, I have come to realize that some of the major causes are self-evident. The subcommittee conducted a hearing last week in which juvenile arsonists were asked why they had reached a point of despair which motivated them to commit arson, and in the two cases that were heard before the subcommittee, both were angry at the fact that their parents had recently divorced.

In other hearings I have attended, I have heard testimony on the tremendous trauma associated with divorce, trauma in the minds and hearts of the kids. My own parents split up. I am not blaming either one of them for any great trauma that I experienced. Yet, today we do have a family breakup rate in the United States which is unprecedented, and which I think is not coincidently linked to the problem of youthful suicide.

I hope that by calling attention to the problem of youth suicide, we will be motivated to find those partial solutions and help in the tragedy.

Thank you.

[The letter and a copy of Senate Joint Resolution 53 follow:]

Luverne, AL, March 20, 1985.

Hon. JEREMIAH DENTON, Jr.,
U.S. Senator, Hart Senate Office Building, Washington, DC.

DEAR SENATOR DENTON: I received a copy of your letter today in interest of the increasing rate of suicide among our youth. I want to thank you for introducing S.J. Res. 53, a Joint Resolution to designate the month of June, 1985, as "Youth Suicide Prevention Month". My husband, Glenn, and I are so interested in anything that can be done in making everyone aware of this overwhelming tragic problem.

On June 23, 1984 (only 9 months ago), our youngest son, Nix, age 22, shot himself in the head in his apartment at the University of Alabama. Never regaining consciousness, he died 3 days later on June 26th. He was a fine loving son, a promising amiable young man, and a senior in Geology who was to have received his degree this past December. All of the clues or symptoms that we are told are usually present have failed to appear in Nix's situtation. We have yet to discover a reason or come across an explanation for his actions. Our small town of Luverne was shocked at Nix's suicide as he was the last person anyone would have thought would make such a choice. Many have said they could see their own child doing this before Nix.

Suicide is such a devastating blow to an entire family. Outsiders do not want to talk about it, either because of the subject itself, or for the fear of the hurt they may cause you. It is difficult for one to see that more hurt comes from the silence which is saying in essence to me that "my child never existed". Suicide is so real to those involved, yet so unbelievable.

Glenn and I have always felt that being a father and a mother was the richest blessing ever bestowed upon us. Our lives have centered around our two sons. There has always been an abundance of love in our home coupled with respect and appreciation for each family member. We had talked to Nix the night before and he sounded so good to us and we detected no problem. His many friends at the University, some who were with him right up until the time he chose to end his life, were not aware of his intentions.

I say all this to point out that suicide can happen at any time to any our children, often when we least expect it, and it does happen to those who seemingly have no reason. Nix was always a very thoughtful child and he left us a note saying he did not know why he was committing suicide and asking us not to worry about him. Had we not had this note, we would not have believed, under any circumstance, that Nix had willfully made a decision to end his life. This was not the way that Nix would have chosen to settle a problem, yet it happened.

Glenn is a retired county agent. I am still working as the Director of the Crenshaw County Department of Pensions and Security. Glenn worked 31 years with 4-H Club youth in the schools. As a social worker, I have worked for the past 36 years with children and youth with all kinds of problems—and yet, we as parents did not recognize the despair in one who was very close to us and one who was one of our most precious possessions. Suicide hurts so deeply that it is indescribable.

Our approach has been to face this "head on". We have tried to be brave for each other, for our oldest son, Boyd, and for my parents. Some days it is most difficult, and then, other days we seem to cope fairly well. We went right back to church, to work and to our daily routines. I have read every article that I have been able to find and some books to try to understand a subject I knew little about. As a family, we discuss our feelings and try to give support to each other and to our son, Boyd. I plan to attend a workshop in Mobile on Thursday, April 19th, offered by The Psychological Associates on "Depression and Suicide Among The Young". I realize we are still searching but maybe in some way we can eventually find answers that will not only help us but others.

I understand that a Suicide Crisis Center has been opened in Tuscaloosa since there have been so many suicides recently. People must be made aware of how often this is happening and to whom.

It is too late for us, but if Glenn and I can in anyway help others, we would be only too glad to do so. To help save our children and to spare other parents and families from going through this traumatic experience would be worth any effort one could put forth.

I want to thank you again for your interest and efforts.

Sincerely,

Mrs. GLENN B. HANDLEY.

99TH CONGRESS
1ST SESSION

S. J. RES. 53

IN THE HOUSE OF REPRESENTATIVES

APRIL 1, 1985

Referred to the Committee on Post Office and Civil Service

JOINT RESOLUTION

To authorize and request the President to designate the month of June 1985 as "Youth Suicide Prevention Month".

Whereas the youth of society represent the hope for the future;

Whereas the rate of youth suicide has increased more than threefold in the last two decades;

Whereas over five thousand young Americans took their lives last year, many more attempted suicide, and countless families were affected;

Whereas youth suicide is a phenomenon which must be addressed by a concerned society; and

Whereas youth suicide is a national problem which can only be solved through the combined efforts of individuals, families, communities, organizations, and government to educate society: Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the month of June 1985 is designated as "Youth Suicide Prevention Month" and the President is authorized and requested to issue a proclamation calling upon the Governors of the several States, the chief officials of local governments, and the people of the United States to observe such month with appropriate programs and activities.

Passed the Senate March 28 (legislative day, February 18), 1985.

Attest: JO-ANNE L. COE,
Secretary.

Senator DENTON. I will ask Senator Simon if he cares to make an opening statement.

OPENING STATEMENT OF HON. PAUL SIMON, A U.S. SENATOR FROM THE STATE OF ILLINOIS

Senator SIMON. I thank you, Mr. Chairman.

I think you have covered some of the basics questions here. Suicide is the second ranking cause of death among Americans between the ages of 15 and 24. The rate of teen suicides has almost tripled in the last 20 years while the rate of adult suicide has remained constant.

I have many more questions than I have answers, I confess. It is a bit startling to note that the suicides among young women are again fairly constant. Among young men there has been a fairly substantial increase.

The National Institute of Mental Health is engaged in a study. We will be hearing from a witness this morning on that. I note that both Florida and California have suicide prevention programs. It will be interesting to see what they are able to do in a constructive way there.

The most basic answer is simply to surround people, whether they are teen-agers or in their eighties, with love. That is the obvious. How we reach people who yearn for a little attention, that we pay attention to them as a society and as individuals. I do not expect Government to come up with all the'answers primarily. It is going to have to be a collective effort among homes and schools and churches and synagogues and others, but I think Government may be able to provide some leadership as to where we go and how we meet this problem. And I look forward to this hearing providing at least some focus on this problem. I hope we can be very helpful here.

Senator DENTON. Thank you, Senator Simon. I agree with all the excellent points you made.

Senator Specter will want to receive the testimony of each and every one of the distingushed group of witnesses. I will, therefore, recess the subcommittee until Senator Specter arrives.

[Short recess.]

OPENING STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA, CHAIRMAN, SUBCOMMITTEE ON JUVENILE JUSTICE

Senator SPECTER [presiding]. The subcommittee will come to order.

I regret the delay in my appearance here today. After this hearing had been scheduled, the House of Representatives Subcommittee scheduled a hearing, dealing with the subject of Conrail, and considering the vital impact of that subject on Pennsylvania, it was necessary that I be there at 9:30 this morning. I thank my colleagues, Senator Denton and Senator Simon, for proceeding with their opening statements. Again I express my regrets to those of you who have been kept waiting, but I think that most of you know that the operations here in the Congress are like a giant juggling act with so many separate committee hearings in progress all the time.

This is the second in a series of hearings on juvenile suicide. We had the first hearing last October 3, 1984, on this subject of great national importance and great personal importance as we find the suicide rate increasing materially among juveniles. One of every five suicides involves young people in the age group of 15 to 24. The suicide rate has increased some 138 percent for this group of young people from 1960 through 1980, and it is the third leading cause of death, over 5,000 per year, or some 13 a day. Just really an astounding rate.

The National Conference on Youth Suicides is planning a meeting for mid June, and I want to congratulate and compliment my colleague, Senator Denton, for his leadership there in conjunction with ACTION. This holds the potential of being a very worthwhile meeting to analyze the causes and to see if we can deal with the problem in a meaningful way with national leadership. The questions which we will be concerned with today, as we were at the October hearing, are the adequacy of current Federal research and prevention efforts, whether the Office of Juvenile Justice and Delinquency Prevention might undertake some additional initiatives on this program and the consideration of legislation for two States, Florida and California, have introduced some innovative ideas.

Philadelphia, my hometown, has a unique hotline which is being put into operation and which really should be doing much, much more about this great national tragedy where, for some perplexing reason, so many young people seek to take their lives really before they have had a chance to establish themselves or get their feet on the ground to really know where their lives are headed, and suddenly they are ended. So we consider this a matter of great importance and the subcommittee will be pursuing the issue with the meeting in June and beyond this hearing.

I am pleased now to call on my distinguished colleague from Kentucky who arrived in Washington very late in the middle of the night from Chicago from a fund raising activity with me, but not a fund raising activity for either Senator McConnell or myself.

Senator McCONNELL. I hope you did not have to get up for a 7:30 meeting like I did.

Senator SPECTER. Mine was earlier.

Senator McCONNELL. In the interest of time, I would ask unanimous consent that an opening statement I prepared appear in the record at this point.

Senator SPECTER. Without objection, so ordered.

Senator McCONNELL. I want to commend the chairman once again for his leadership in convening these bearings, and I think it appropriate we go right ahead with the witnesses.

[The prepared statement of Senator McConnell follows:]

PREPARED STATEMENT OF HON. MITCH McCONNELL A U.S. SENATOR FROM THE STATE OF KENTUCKY

Mr. Chairman, I commend you for holding this hearing designed to help deal with the problem of youth suicide—perhaps one of the most disturbing phenomena of those that this Subcommittee has been called upon to examine.

More alarming even than the fact of suicide among our nation's young people is the steady rate of increase with which suicide occurs in our adolescent and sometimes even pre-adolescent population. In 1950 the suicide rate for the 15–24 year old age group was 4.9 per 100,000 persons. By 1983 that rate was 11.7 per 100,000, a nearly three-fold increase.

While much has been done in the past few years to develop new approaches to the problem, much remains to be done. Indeed, the statistics indicating that the rate of teenage suicide has been steadily increasing suggest that even new, more effective approaches need to be developed if the problem is to be solved. Perhaps as important as any aspect of the search for the solution is the need to counter the attitudinal problems that lie at the core of the problem.

The social pressures exerted on adolescents, combined with the adolscent's often powerful feeling of isolation, as well as the sense of shame with which we often approach the subject of suicide, made the solution elusive. Perhaps as much as anything else, we need to work on finding ways to promote the kind of atmosphere for our young people in which suicide will not be considered and option. A first step may be increasing awareness of the problem in the adult population, by stripping away the silence in which we so often shroud it.

I am hopeful that this hearing will be a step in the right direction, and that as a result of it we will have greater insight into the problem. Ultimately, our aim is to find out how the federal government can assist the state and local agencies that must deal with youth suicide first hand, and if these hearings can help foster a new attitude of communication, understanding and respect between young people and adults, we may reach that goal.

I look forward to the testimony of the witnesses, and commend you once again. Thank you, Mr. Chairman.

Senator SPECTER. I would now like to call on our first panel consisting of Hon. Dorcas R. Hardy, Assistant Secretary for Human Development Services, Department of Health and Human Services, and Dr. Larry Silver, Deputy Director, accompanied by Dr. Susan Blumenthal, Chief of Suicide Research Unit, National Institute of Mental Health in Rockville, MD.

We welcome you and look forward to your testimony, and would like to begin with Secretary Hardy.

STATEMENTS OF PANEL INCLUDING HON. DORCAS R. HARDY, ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND LARRY B. SILVER, M.D., DEPUTY DIRECTOR FOR SPECIAL PROJECTS, NATIONAL INSTITUTE OF MENTAL HEALTH, ACCOMPANIED BY DR. SUSAN BLUMENTHAL, CHIEF, SUICIDE RESEARCH UNIT, NATIONAL INSTITUTE OF MENTAL HEALTH

Ms. HARDY. Thank you, Mr. Chairman.

I am pleased to have the opportunity to appear before you today to discuss the problem of youth suicide and to share information with you on what we are doing in the Office of Human Development Services to combat youth suicide.

Within my office, the Administration on Children, Youth and Families, the agency responsible for administering the national runaway and homeless youth program, has taken the lead to mobilize resources to respond to this problem among our youth.

We have discussed, and you have alluded to statistics that address the problem of youth suicides throughout the country, and my colleagues at the National Institute of Mental Health will also be addressing that. But I should comment that NIMH has recently reported that every 90 minutes an American teen-ager commits suicide. The American Psychiatric Association has also reported that although the incidence of suicide among young people ages 15 to 24 has recently reached a plateau, it has risen dramatically over the past 30 years, by as much as 300 percent, and specifically the rate climbed from over 4.1 per 100,000 in the 1950's to 12.5 per 100,000 in 1980. Nevertheless, research tells us these deaths are only the tip of the iceberg and that youth suicides tend to be underrecorded because of the social, legal, religious and economic stigma that accompanies self-destructive acts. Families who cannot bear the increased burden of society's negative response, along with intense personal pain caused by the loss of a child, may understandably want to attribute the death to a more "acceptable" cause.

Such behavior is an attempt to deal with the enormous stress placed on the family when a suicide occurs. Now, no segment of the youth population is free from this tragedy. It occurs to youth in rural areas and in urban areas. It occurs to rich youth and to poor youth. It occurs among white youth and minority youth at nearly equal rates.

Only between the sexes do we see significant differences in suicidal acts. Young women account for 90 percent of suicide attempts, while boys account for 70 percent of the "successful" suicides.

So who is at risk and how are we to recognize youngsters who are in imminent danger of becoming victims of this tragedy? And, most important, how can we prevent it?

Although it is difficult to pinpoint the exact causes, it is possible to identify indicators that often mark the potential suicide victim. And as part of an interagency agreement with my office, the Administration on Children, Youth and Family and ACTION are developing several brochures which are targeted to potential volunteers, to youth, to adults, and especially school personnel, that describe the danger signs and the need to take these signals very seriously.

Among the danger signs that are listed for consideration by parents, teachers, and others are direct suicide threats, statements revealing a desire to die, previous suicide attempts, perhaps sudden changes in behavior like withdrawal or apathy, moodiness, depression, and making final arrangements such as giving away personal possessions.

The brochures also outline steps that parents and teachers and friends who notice these symptoms can take to help, because assistance is available. They need to discuss these symptoms openly and frankly. They need to show interest and support. They need to get professional help. They need to communicate.

Now, from what we already know about this tragedy, it is clear there is no one single answer or program that will solve the problem, and it is also clear to me that this is not a Federal problem, or a State problem, or a public versus a private problem. It is a problem for all of us and a problem that calls for the involvement of all segments of our society.

I am pleased to report that there are constructive efforts underway nationwide to confront this problem. There is a leadership role that the Federal Government is playing in raising public awareness, information dissemination, research and demonstrations of the kind of services that might help, and generally working in partnership with all of our governments and private organizations to expand community involvement in addressing the problem.

We are actively engaged in finding ways of reaching out to youngsters at risk through existing service networks. From the more than 265 runaway and homeless youth shelters which my agency supports, we have learned that the probable risk factors associated with suicidal youth are notably more prevalent among runaway and homeless youth than among youth in general. High incidence of family problems, low self-esteem, physical and sexual abuse and neglect are all reported among this population.

Recognizing that our nationwide network of shelters gives us a way to reach youth at risk of suicide, in August 1984, we announced the availability of funding for projects to identify or develop effective techniques for intervention and for providing emergency services to seriously depressed and suicidal youth who use shelter facilities. We want to respond to shelters' concerns about recognizing suicidal clients, and we hope to encourage them to work jointly with community mental health agencies to develop guidelines and procedures that can be used when a client does need help.

We have just completed the final stages of the competitive review process, and this week we will be announcing the funding of seven projects totaling over $600,000. Within the next year, all runaway shelters will receive special assistance and guidance on how to screen for and intervene with potentially suicidal youth in our runaway shelters.

The second major effort which you addressed earlier is the first National Conference on Youth Suicide, to be held later this year in Washington. Its objectives are to increase national awareness of the problem of youth suicides, and to encourage expanded, community-based strategies for addressing the problem.

Mental health professionals are a vital part of this community network, and the conference will call upon the best of their ranks to explain the problem and inform the Nation of the latest research and treatment advances. We also will be including youngsters and parents who have been directly touched by suicide in their lives.

I would like to emphasize our commitment to expanding community-based responses to these problems because we believe that the first line of prevention——

Senator SPECTER. Dr. Hardy, your entire statement will be made a part of the record, so to the extent you could summarize, we would appreciate it.

Ms. HARDY. Thank you, Senator.

I think the community response is very important, and we know that the kinds of awareness and the kinds of actions that we intend to have throughout the government will be successful, we believe, in having a very significant impact on the prevention of this tragedy.

Thank you, Senator.

[The prepared statement of Ms. Hardy follows:]

PREPARED STATEMENT OF DORCAS R. HARDY

Mr. Chairman, and Members of the Committee, I am pleased to have the opportunity to appear before you today to discuss the alarming problem of youth suicide and to share information with you on what we are doing in the Office of Human Development Services (OHDS) to combat it. Within my office, the Administration on Children, Youth and Families (ACYF), the agency responsible for administering the national runaway and homeless youth program, has taken the lead to mobilize resources to respond to this problem among our youth.

THE PROBLEM

I would like to begin by outlining briefly the dimensions of the problem of youth suicide in our country. The statistics, although they differ slightly from study to study, are frightening.

My colleagues at the National Institute of Mental Health (NIMH) recently reported that every 90 minutes an American teenager commits suicide.

The American Psychiatric Association reports that although the incidence of suicide among young people age 15 to 24 has recently reached a plateau, it has risen dramatically over the past 30 years - by three hundred percent. Specifically, the rate climbed from 4.1 per 100,000 in the 1950's to 12.5 per 100,000 in 1980. The suicide rate for teenagers rose 41 percent between 1970 and 1978.

However, researchers tell us that these deaths are only the tip of the iceberg. Youth suicides tend to be under-recorded because of the social, legal, religious, and economic stigma that accompanies self-destructive acts. Families who cannot bear the increased burden of society's negative response, along with the intense personal pain caused by the loss of a child, may understandably want to attribute the death to a more "acceptable" cause.

Such behavior is an attempt to deal with the enormous stress placed on the family when a suicide occurs. Not only must grief and loss be handled, but loved ones must also cope with a sense of guilt for the suicide. Researchers have suggested that many drug overdoses, fatal car accidents, and other self-destructive behaviors, such as eating disorders and alcohol abuse are, in fact, teen suicides masquerading under other names.

No segment of the youth population is free from this tragedy. It occurs to youth in rural areas and in urban areas; it occurs to rich youth and to poor youth. It occurs among white youth and minority youth at nearly equal rates.

Only between the sexes do we see significant differences in suicidal acts. Young women account for 90 percent of suicide attempts, while boys account for 70 percent of the "successful" suicides.

Who is at risk? How are we to recognize youngsters who are in imminent danger of becoming victims of this tragedy? Most important, how can we prevent it?

RECOGNIZING YOUNGSTERS AT RISK

Although it is difficult to pinpoint exact causes, it is possible to identify indicators that often mark the potential suicide victim. As part of an interagency agreement with my office, ACYF and ACTION are developing several brochures targeted to potential volunteers, youth, adults, and school personnel, describing the danger signs and the need to take these signals seriously. Among the danger signs listed for the consideration of parents and teachers are:

- Direct suicide threats
- Statements revealing a desire to die
- Previous suicide attempts
- Sudden changes in behavior (withdrawal, apathy, moodiness)
- Depression (crying, sleeplessness, lost of appetite, hopelessness)
- Making final arrangements (such as giving away personal possessions.)

The brochure also outlines steps the parents, teachers and friends who notice these symptoms can take to help:

- Discuss it openly and frankly
- Show interest and support
- Get professional help.

WHAT CAN WE DO?

From what we already know about this tragedy, it is clear that there is no single answer or program that will solve the problem. It's also clear that this is not a Federal problem, or a State problem, or a public versus private problem. It is a problem for all of us, and a problem that calls for the involvement of all segments of our society.

I am pleased to be able to report that there are constructive efforts underway nationwide to confront this problem. There is a leadership role the Federal government can play and is playing in raising public awareness, information dissemination, research and demonstration of the kinds of services that might help, and generally working in partnership with State and local governments and private organizations to expand community involvement in addressing the problem.

We are actively engaged in finding ways of reaching out to youngsters at risk through existing service networks. From the 265 runaway and homeless youth shelters my agency supports, we have learned that the probable risk factors associated with suicidal youth are notably more prevalent among runaway and homeless youth than among youth in general. High incidence of family problems, low self-esteem, physical and sexual abuse and neglect are all reported among this population.

The prevalence of these factors has led researchers to identify those youth seeking shelter services as having a greater potential of suicidal risk than adolescents in general. A 1984 report on "Runaway and Homeless Youth in New York City" (Drs. David Shaffer and Carol Caton in January 1984, Report to the Ittleson Foundation) found that "no fewer than 33 percent of the girls and about 15 percent of the boys had previously attempted suicide." Another 33 percent of both girls and boys admitted previously contemplating or threatening suicide.

Recognizing that our nationwide network of shelters gives us a way to reach youth at risk of suicide, in August 1984, we announced the availability of funding for projects to identify or develop effective techniques for intervention and for providing emergency services to seriously depressed and suicidal youth who use shelter facilities, and that would further distribute information gained among the network of shelters. We want to respond to shelters' concerns about recognizing suicidal clients and we hope to encourage them to work jointly with community mental health agencies to develop guidelines and procedures that can be used when a client needs help.

We have just completed the final stages of the competitive review process on the applications responding to this announcement. This week we will be announcing the funding of seven projects, totalling over $600,000. Within the next year, all runaway shelters will receive special assistance and guidance on how to screen for and intervene with potentially suicidal youth in runaway shelters.

The second major effort that OHDS is spearheading is the first National Conference on Youth Suicide, to be held later this year in Washington, D.C. Its objectives are:

- To increase national awareness of the problem of youth suicides; and
- To encourage expanded, community-based strategies for addressing the problem.

Mental health professionals are a vital part of this community network, and the conference will call upon the best of their ranks to explain the problem and inform the nation of the latest research and treatment advances. We will also include youngsters and parents whose lives have been directly touched by a suicide, and who have insights on what might be done in the family and in the community to prevent further senseless waste of young lives.

Let me emphasize our commitment to expanding community-based responses to this problem. We believe that the first line of prevention, identification, and intervention must come from parents and local institutions with which youngsters come into everyday contact -- schools, churches, volunteer and youth service groups, recreational clubs, PTAs, and so on.

Last fall the Committee heard testimony on how local school systems can help prevent the problem of teen suicide. In addition to the runaway shelters and mental health centers, there are other community based initiatives underway. I was pleased to learn recently that Parents Anonymous, a self-help network with over 1500 local chapters committed to reducing child abuse, has created a rapidly increasing number of self-help groups for teenagers, through which youngsters can reach out to troubled youth for help and support from their peers, under the guidance of a professional. We have encouraged and provided financial support for this Parents Anonymous activity. We are pleased with the enthusiastic community response they have helped to generate.

But these and other services supported by public and private agencies cannot be called into play until and unless someone realizes that help is needed. Awareness that the teenager who seems to have all the adolescent problems conquered may be sending out subtle signals for help is part of the solution. We expect the national conference to be only one part of a coordinated campaign for raising public awareness and providing information to help.

The brochures and educational materials I mentioned earlier are another component. Building the awareness of teachers, parents, and peers is the first and most valuable step, and to reach each group effectively specialized materials are being developed. The joining of forces by ACTION and the Department of Health and Human Services will ensure broad and successful dissemination of the materials.

In addition, jointly with ACTION we are producing public service announcements and special efforts to use the ability of the mass media to reach great numbers of parents and youth.

In summary, I have described the scope of the particularly tragic problem of teen suicide. At the same time I have indicated that there is reason for hope. Recognition of the problem has stirred a strong response from major agencies of the Federal government acting together, from State governments such as California, and from existing community agencies such as runaway shelters, Parents Anonymous chapters, school systems and mental health centers. Efforts are being directed at dealing with the problem in the community where the impact is needed. I have every expectation that in the coming years these efforts will succeed and the tragedy of teen suicides will be reduced.

I would like to thank this Committee for making this issue one of its priorities and for inviting us to testify.

Senator SPECTER. Thank you very much.

I would like now to turn to Dr. Silver, Deputy Director of NIMH since 1981, previously a professor of psychiatry, professor of pediatrics, and chief of child psychiatry at Rutgers Medical School.

We welcome you, Dr. Silver, and we look foward to hearing your testimony.

STATEMENT OF DR. LARRY B. SILVER

Dr. SILVER. With your permission, I would like to submit my formal statement for the record and summarize it at this time.

Senator SPECTER. That will be fine. All statements will be made a part of the record in full and to the extent they can be summarized, leaving the maximum time for questions and answers, the subcommittee would appreciate it.

Dr. SILVER. Mr. Chairman and members of the Subcommittee on Juvenile Justice, it is a pleasure to be here today to testify for the Public Health Service. I would like to commend you and your subcommittee on being concerned about this serious problem and on holding this hearing.

I am Dr. Larry B. Silver, Deputy Director for Special Projects of the National Institute of Mental Health. I would like to introduce Dr. Susan Blumenthal, head of the Suicide Research Unit at the National Institute of Mental Health.

In my testimony I would like to summarize the research we at NIMH are doing as well as talk about the other activities we are working on with other agencies. I will not review the scope of the problem since this has already been discussed.

The Public Health Service is concerned about many aspects of teen suicide. One concern is risk factors. If we can recognize these factors that put a teen at risk for suicide, we can move in and do something about it. What are these psychological, biological and/or social or cultural risk factors?

One area of concern is psychiatric risk factors. While not all young people who attempt or commit suicide have an underlying psychiatric disorder, depression and chemical dependence are important risk factors. We know that people who have conduct disorders, that is, difficulty handling their behavior in a manner that is functional and acceptable in society, and who are also impulsive and aggressive, are at risk. Our research is directed toward learning more about these factors and developing models of intervention.

We are concerned about psychosocial risk factors such as those mentioned earlier by Senator Denton. Individuals who have experenced losses are much more likely to attempt suicide. This might be the loss of a loved person, multiple geographical moves and stresses within their lives, chronic illness, being a victim of child abuse, being a runaway, having an unwanted pregnancy or experiencing a humiliation in front of family or friends. We also know that individuals who are more isolated or who show antisocial behavior are more at risk so we want to study this.

Recently we have learned of certain populations of suicide attempters or successful suiciders who appear to have biological risk factors. If the research turns out to be true, there might someday be biologic measurements to better identify some individuals who have a history of aggressive behavior and who might be at high risk for attempting suicide.

A family history of suicide increases the risk of suicide eightfold; and, therefore, there is also research going on relating to genetic and familial risk factors. Perhaps the most publicized phenomenon is the suicide cluster phenomenon. When a suicide occurs it is possible that it will spread within that population; others are likely to attempt suicide. We do not fully understand this phenomenon. The Centers for Disease Control and the NIMH are studying the various factors involved in this clustering phenomenon.

In terms of future research, the National Institute of Mental Health and the Public Health Service need to focus research on high risk populations and on preventive interventions. There is a need to do more epidemiologic studies to better understand who attempts suicide versus who completes suicide. What the differences are relating to demographics, psychological profiles, family issues, social issues. We want to look further into psychiatric disorders that are likely to make one prone to suicide, and what we might do to intervene and treat these individuals. We are interested in further pursuing the psychosocial risk factors. What goes on in the family or the individual's life that might be of importance in predicting a risk for suicide. What goes on in the broader society, their school environment, their peer groups that might help predict a person at risk.

Once we can recognize these issues, we might move in and do something about it. And we want to continue our work in terms of biological risk factors.

The National Institute of Mental Health and the Alcohol, Drug Abuse, and Mental Health Administration have been working very closely with ACTION, on an initiative that is funded by the Office of Human Development Services to develop programs related to teen suicide. We have worked with them in developing brochures and in planning a conference scheduled for June 1985.

We have also worked closely with the Centers for Disease Control, collaborating on epidemiological studies to better understand the problem, and with the National Center for Health Statistics. We have also been working very closely with the American Association of Suicidology, the American Psychiatric Association, the American Psychological Association, and other professional organizations.

In conclusion, we feel that improvement can be achieved only through careful scientific inquiry and evaluation. Psychiatric, psychoiogical, biological, genetic, and other factors that might contribute to suicide must be studied. While we work to increase our knowledge, we must also continue to work closely with professionals and other individuals who are concerned about this problem.

I thank you for this opportunity to testify today on behalf of the Public Health Service, and look forward to answering any questions you might have.

[The prepared statement of Dr. Silver follows:]

PREPARED STATEMENT OF DR. LARRY B. SILVER

Mr. Chairman and Members of the Subcommittee on Juvenile Justice, it is an honor to be invited here today to testify on behalf of the Public Health Service and specifically the Alcohol, Drug Abuse and Mental Health Administration on the subject of teenage suicide. I am pleased that the Subcommittee is concerned about this major public health problem in our country and would like to commend your leadership role in examining this area of national concern.

I am Dr. Larry B. Silver, Deputy Director for Special Projects of the National Institute of Mental Health (NIMH), one of the three Institutes of the Alcohol, Drug Abuse, and Mental Health Administration. With me today is Dr. Susan Blumenthal, Head of the Suicide Research Unit at the National Institute of Mental Health. The Suicide Research Unit coordinates NIMH's program in suicide research, funds and conducts research projects, organizes conferences and workshops, collaborates with other Federal agencies, prepares scientific presentations about suicide for professional groups and to the public and disseminates information about suicide to the public and health care professionals.

In my testimony, I will address our current ADAMHA efforts in research, education, and prevention. As you know, service activities in this area are funded from the Department's Office of Human Development Services.

The professionals of ADAMHA share a deep concern with the tragic loss of life through teenage suicide and the emotional toll it takes on the survivors. A better understanding of this problem leading to better recognition of at-risk individuals, better prevention programs, and improved clinical interventions is essential.

SCOPE OF THE PROBLEM:

. Over the past 30 years, the United States suicide rate for people 15 to 24 years of age has increased dramatically from 4.1

per 100,000 in the mid-1950's to 12.5 per 100,000 in 1980. As a consequence, suicide moved from the fifth leading cause of death in this age group in 1960 to the third leading cause in 1982. Research data also indicate that suicide is the second leading cause of death among college students. Between 1970 and 1978, 39,011 United States residents 15 to 24 years of age committed suicide. During this same period, the suicide rate for this age group increased 41 percent while the rate for the rest of the population remained stable. However, the incidence of suicide among young people aged 15-24 has leveled off recently.

This increase in reported suicides for young people is due primarily to an increasing number of suicides among young white males; rates for males increased by 47.4 percent compared with an 11.9 percent for females so that by 1978, the ratio of suicides committed by males to those by females was greater than 4 to 1. Young people who attempt suicide and those who complete suicide represent different groups characterized by different risk factors. For example, young women attempt suicide 4 to 8 times more frequently than males. Recent data also make evident the seriousness of the suicide problem in inner-city Black males. The problem is widespread and touches every segment of society.

Adolescents are not only more likely to attempt suicide, they are also more likely to use lethal methods in those attempts. From 1970 to 1978, the proportion of suicides committed by firearms or explosives increased for both males and females, while the proportion of both males and females committing suicide by poisoning declined. These changes were more marked among young women, who have traditionally committed suicide by poisoning.

Suicidal behavior in younger children is an unrecognized problem. A recent study has shown that 13 percent of the 6 to 12-year-olds randomly selected from Westchester County elementary and junior high schools had suicidal thoughts, and 3 percent had made suicide attempts that had not previously come to anyone else's attention.

The Centers for Disease Control (CDC) has recently established a Violence Epidemiology Branch to carry out research to reduce the incidence of suicide related morbidity and mortality. CDC's objective is to characterize those susceptible individuals so that appropriate interventions can be designed, implemented, and evaluated.

CDC has established a working group for the purpose of exploring the best approach to develop and implement uniform reporting criteria. Calculations of suicide incidence based on death certificates probably underestimate the true incidence for all ages. One important factor contributing to this underestimate is the lack of uniform criteria for use by medical examiners and coroners in the classification of suicide deaths. This is particularly true of death by suicide of children and adolescents.

CURRENT RESEARCH EFFORTS:

The NIMH's primary mission in the area of youth suicide is research. Currently funded research focuses on the biological factors associated with violent behavior/suicide, epidemiological studies, including detailed retrospective analysis of completed and attempted suicides compared with a control group of adolescents.

Risk Factor Research. There are many reasons why young people commit suicide. The factors involved are complex, highly interrelated, and only partially understood. Its causes are psychological, biological, and sociocultural.

- Psychiatric Risk Factors--While not all young people who attempt or commit suicide have an underlying psychiatric disorder, depression and chemical dependence are important risk factors for suicide. Young people who have disorders involving their conduct (such as truency, stealing, confrontations with the law, and running away from home) and are more impulsive and aggressive are at increased risk for suicide. One of our most important prevention strategies is the early detection and treatment of mental disorders and chemical dependence.

- Psychosocial Risk Factors--These include loss of a loved person, multiple moves and stresses as the young person has developed, chronic illness, being the victim of child abuse, being a runaway, having an unwanted pregnancy, and having experienced a recent humiliation in front of family or friends. Personality characteristics of adolescents who complete suicide have included antisocial behavior and/or a history of aggressive and impulsive behavior, isolated, depressed youngsters and perfectionistic young people who experience injuries to their self-esteem.
- Biological Risk Factors--Recent biochemical investigations of suicidal behavior have shown reduced levels of serotonin, a key chemical messenger in the brain, associated with increased aggression in violent suicide attempts and completions which may increase the risk of completed suicides twenty-fold. Research on biological factors may hold promise for increased prediction of suicide, new psychopharmacologic treatment interventions and ultimately prevention of suicide.
- Genetic and Familial Risk Factors--A family history of suicide increases the risk of suicide eight-fold. Explanations for this include the psychological phenomenon of identification with a family member who has committed suicide, genetic factors for suicide, and the genetic transmission of psychiatric disorders.
- Suicide Clusters--Another characteristics of the

current suicide problem merits serious concern. "Suicide clusters" are occurring at an increasing rate among adolescents. The term, "suicide cluster," refers to the phenomenon of one suicide appearing to trigger several other suicides in a group, such as a school or community. Very little is known about this apparent contagion effect of suicide among adolescents. Suicide clusters have recently occurred in Plano, Texas, in Westchester County, New York, in Minnesota, and in Clear Lake and Houston, Texas. NIMH funded studies are underway at Columbia University to investigate the mechanism of suicide clusters. Analysis of these data should be completed by December, 1985. Increased understanding of these factors should lead to prevention strategies.

In addition, the Centers for Disease Control (CDC) assisted the Texas State Health Department in investigating apparent clusters of teen suicides in Plano and Clear Lake, Texas, in order to identify the degree to which youth suicides may be influenced by other deaths or suicides. In December 1984, CDC delivered to the Texas Department of Health and the city of Plano a preliminary report analyzing demographic and situational data for a cluster of eight suicides. CDC was successful in establishing effective working relationship with school and community leaders in both Plano and Clear Lake. These will serve as models for future research efforts in the area of teen suicides.

CDC plans to complete the analysis of teen suicide clusters in Plano and Clear Lake by October 1985. CDC also plans to work with the Texas Research Institute of Mental Sciences to refine the questionnaire used in the CDC epidemiologic investigations and to make it available to communities and States in which additional clusters of teenage suicides are identified.

FUTURE RESEARCH DIRECTIONS

The variation in suicide-death rates in different age, sex, and ethnic population groups suggests the existence of high-risk and protective factors. More research is needed before we can infer the nature of these factors. Since only a few studies have been focused exclusively on children and adolescents, much more research is needed to form the basis for rational treatment and prevention.

Areas in which further research is needed:

- o Epidemiologic--Including the collection of better statistics on adolescent suicide with associated demographic and psychosocial factors.
- o Psychiatric--What is the prevalence of clinical diagnosis among adolescents who attempt and commit suicide, in particular, the proportion of affective disorder, psychotic or conduct disorders. In addition the prevalence of the association of alcohol and drug abuse and dependence associated with suicide needs to be determined.
- o Psychosocial-- Are there precipitating events among individuals sno suicide or attempts suicide, such as physical illness, familial disruption or other factors. physical illness, familial disruption and other factors needs to be determined.
- o Genetic/Familial--What is the extent to which genetic or family history of suicide contributes to suicidal behavior in adolescents.
- o Biological--What are the biological risk factors and possible biological markers for suicide in adolescents.
- o Preventive Interventions - What is the effects of high school suicide prevention education programs on young people. The development of evaluation components for these programs is essential.

Determination of what educational methods, services, and treatment strategies are effective in preventing adolescent suicide is needed.

ADAMHA'S RESPONSE TO THE NATION'S SUICIDE PROBLEM

The NIMH's primary mission in the area of teenage suicide is research. The NIMH established a Suicide Research Unit (SRU) to develop a knowledge base and to stimulate and support research related to suicide. Through its research support, NIMH hopes to reduce the suicide rate in high-risk populations through improved diagnosis and treatment of psychiatric disorders. In addition to its research activities, the SRU collects and disseminates information about suicide to the public, professionals, and the media and coordinates suicide-related activities within the NIMH. Among the suicide related activities carried out by the Suicide Research Unit in collaboration with other NIMH programs include:

Research:

- NIMH Extramural Research Program The NIMH currently sponsors nine research projects on suicide in its extramural program at a total cost of $829,273. A new solicitation for research projects on Suicide is planned for FY 1986. In addition there are 18 other NIMH grants dealing with some aspect of suicide. The total amount of funding related to suicide research is $1,000,000.
- NIMH Intramural Research Program Intramural research at the NIMH includes studies on possible biological markers for suicide, the relationship of biochemical factors, aggression and suicide, familial factors in suicide, alcohol abuse and suicide, and research on affective disorders.
- National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism. The use of alcohol and drug abuse may reflect an underlying emotional

problem or may by it's use add to the stress or influence the judgment of the individual. Thus, substance abuse is a risk factor for suicide. Research efforts related to these issues are in progress.

Prevention - The NIMH is approaching the prevention of suicide in a number of ways:

o Project Depression A major prevention strategy is the early detection and treatment of affective disorders. Since the presence of an affective disorder such as depression is a common precursor of suicide, the NIMH is developing a major public and professional education campaign on depression. The goal of this program is to increase the recognition, early detection, diagnosis, and treatment of depression. This initiative is expected to help decrease the suicide rate and the number of attempted suicides in this country.

o Early detection - Currently the most effective strategy for prevention of suicide is the early detection and appropriate treatment of depression, substance abuse, and other psychiatric disorders. In order to foster earlier detection and more effective treatment, more comprehensive education is needed for individuals at high suicidal risk, their families and loved ones, primary care physicians, and other health care providers and mental health specialists. The ADAMHA is planning activities to improve primary care physician awareness of alcohol and drug abuse, chemical dependency, and mental health disorders. One outcome which should result from this is a decrease in suicide attempts and completions.

o Preventive Interventions - NIMH is planning evaluation research to test the type and effects of specialized high school suicide education programs and curricula on young people. The preventive effectiveness of suicide hotlines and crisis centers has yet to be systematically proven. Yet, this lack of evidence should not be interpreted to mean that hotlines and centers are ineffective. It is unclear that people who contact suicide hotlines are those individuals at highest risk for completing suicide. Therefore, a review of this suicide prevention literature has been commissioned to assess current knowledge about the effectiveness of suicide education programs, hotlines, and suicide crisis centers. Based on this review, recommendations for evaluation of educational and service programs and prevention strategies will be developed. Further NIMH-sponsored research is planned to clarify what populations utilize these services, what services are offered, and to evaluate the effectiveness of interventions offered.

Education - Closely related to our prevention activities are the information and educational efforts:

- Publications and Information Dissemination A series of publications and informational materials on suicide for the public and scientific community are being prepared. These include a new suicide monograph for the general public, a videodisc on the assessment of adolescent suicidal behavior for medical students and resident trainees, and a monograph on black suicide. The NIMH continues to work actively with the media to promote public education about suicide and responds to numerous public and professional inquiries on suicide.
- Conferences and Workshops The suicide research unit is planning a series of workshops and

conferences that will bring together researchers, clinicians and education experts to present research findings to develop future directions for research and prevention activities.

- NIMH sponsored a workshop on "Prevention Research: Suicide and Affective Disorders Among Adolescents and Young Adults," in December 1982.
- NIMH will co-sponsor with the New York Academy of Sciences a 3 day Conference on "The Psychobiology of Suicidal Behavior" to be held September 18-20, 1985. Research on psychosocial, behavioral and biological risk factors for suicide will be presented and future lines of research will be discussed.
- Workshops--Workshops on the Contagion Effect in Adolescent Suicide, Prevention of Suicide, and the Effectiveness of Treatment Strategies for Suicidal Adolescents are planned in FY 1985 and FY 1986.

Collaboration with Other Federal Agencies and Outside Groups

- ACTION - The Department has entered into an interagency agreement with ACTION to address the issues of youth suicide. A number of activities are in progress: (1) informational pamphlets for teenagers, parents and high school teachers on the prevention of adolescent suicide; (2) a two day Conference on Adolescent Suicide to be held June 19-20, 1985; and (3) public service announcements for television on the prevention of youth suicide.
- Within DHHS - The NIMH collaborates with other Federal agencies (including the Centers for Disease Control (CDC) and National Center for Health Statistics) to improve surveillance mechanisms and the data base for suicide information in this country. The latest published

compilation of national suicide statistics for all ages was in 1984. For youths, no detailed compilation of suicide statistics at the State, regional, and national level has ever been published. As a consequence, we lack the statistical basis for defining the scope and characteristics of suicide as a public health problem. The CDC-NIMH Adolescent Suicide Project has analyzed trends in youth suicide from 1970-1980. This CDC-NIMH collaborative agreement will result in a two-part Suicide Surveillance Report on national suicide statistics for the years 1970-1980. Part 1 is primarily a report of suicide incidence by age, race, sex, and geographic area. Part II is a more detailed report focusing on youth suicide (ages 15-24). This two-part Suicide Surveillance Report will provide background data for monitoring and reducing the youth suicide rate.

o Collaboration with Professional Organizations The NIMH is working with the American Association of Suicidology, the American Psychiatric Association, the American Psychological Association and other professional organizations to increase professional and public awareness about youth suicide.

NIMH BUDGET FOR SUICIDE-RELATED PROGRAMS AND ACTIVITIES

	1984 Actual	1985 Estimate	1986 Estimate
Research	$1,000,000	$1,200,000	$1,400,000
Program Support (i.e., Video Disc, CDC-NIMH Collaboration, Other)	200,000	150,000	250,000
	$1,200,000	$1,350,000	$1,650,000

CONCLUSIONS:

Improvement can be achieved only through careful scientific inquiry and evaluation. New research on psychiatric, psychosocial, biological, and genetic risk factors for suicide, as well as basic and applied research on affective disorders, is required.

We must strengthen our knowledge about psychiatric, psychosocial, biological, and genetic risk factors for suicide. At present the research evidence points to early detection and effective treatment of depression, alcoholism, drug abuse, and other psychiatric disorders as the best chance to reduce the suicide rate in young people.

The Department will continue its PHS leadership role by providing information learned from research and by working with the leadership of ACTION, the National Committee for Youth Suicide Prevention, the American Association of Suicidology, the Drug and Alcohol Abuse Treatment Program and other programs or organizations concerned about this problem. In addition, ADAMHA professionals will continue to actively participate at national meetings and special conferences, trying to increase the awareness of health and mental health professionals, education professionals, and the public about current suicide research, prevention strategies and interventions.

Thank you for the opportunity to testify today on the subject of suicide on behalf of the Public Health Service. I would be happy and eager to provide the Subcommittee with any further information you should require.

American
Psychiatric
Association

1400 K Street, N.W.
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Facts About:
TEEN SUICIDE

The teens are years of turmoil for just about everyone. You're learning new social roles, developing new relationships, getting used to the changes in your bodies, making decisions about your future. And when you're looking for answers to problems, it seems like no one has them. That can make a person feel pretty much alone.

So when a particularly hard challenge comes along — facing friends after what feels like a public humiliation, doing poorly on a school exam, watching parents divorce or separate — you probably begin to feel depressed and to wonder if life is worth living. It might sound like a platitude, but **the truth is that only by having enough "life experience" will you realize time can — and does — ease much of the hurt.**

You might need some extra support to hold on. If you're depressed, talk it over with someone — a close friend, a school counselor, your minister or rabbi, or a mental health professional.

Depression is a very common illness, even among teenagers. Your health and grades can be hurt. Worse, people with depression have a high risk for suicide. Half of those who suffer one episode of serious depression will have another one. **But with adequate treatment, 80-90 percent of all depressed people begin to get better within about a month.**

WHAT TO LOOK FOR: Everyone has normal mood swings in which he or she occasionally feels down in the dumps, sad or unhappy. But **when that depressed mood lingers for more than two weeks, serious depression could be setting in.** That's dangerous, because 15 percent of people who suffer severe depression kill themselves.

- **If two or more of the statements below describe you or a friend, you probably should find help** by talking to a mental health professional or other trusted adult such as a parent or a school counselor — about how you feel.

    I am sleeping much later than I used to; I'm not sleeping well and wake up early in the morning; or I'm beginning to take a lot of naps.

    My appetite has changed, and I've noticeably lost or gained weight.

    I feel restless.

    I have withdrawn from friends and family.

    I can't concentrate very well.

I've lost interest or pleasure in usual activities that I once enjoyed.

I feel hopeless or guilty.

I've had sudden mood or behavior changes: I used to be quiet and now I am hyperactive; or once I was an outgoing youth and now I'm withdrawn.

I have thoughts that life isn't worth living.

- **Young people who have attempted suicide in the past or who talk about suicide are at greater risk** for future attempts. Listen for hints like, "I'd be better off dead" or "I won't be a problem for you much longer" or "Nothing matters; it's no use."
- **Adolescents who consider suicide generally feel alone, hopeless, and rejected.** They are more vulnerable to having these feelings if they have been abused, feel they have been recently humiliated in front of family or friends, have parents with alcohol or drug problems, or have a family life with parental discord, disruptions, separation or divorce. However, a teenager may be depressed and/or suicidal without any of these.
- **Many teens who abuse alcohol or drugs are likely to consider, attempt or succeed at suicide.** The Fifth Special Report to the U.S. Congress on Alcohol and Health (1983) found that as many as 80 percent of people who attempt suicide have been drinking at the time. And alcohol is a depressant.
- **Teenagers who are planning to commit suicide might "clean house" by giving away favorite possessions, cleaning their rooms, or throwing things away.** They may also become suddenly cheerful after a period of depression, because they think they have "found the solution" by deciding to end their lives.
- **One of the most dangerous times of a teen's life is when he or she has suffered a loss or humiliation of some kind:** loss of self-esteem by doing poorly on a test, the breakup with a boyfriend or girlfriend, or the trauma of parents' divorce.

NEW FINDINGS: Every day, psychiatric research is finding new clues to the causes of depression and suicide. Among them:

- **Depression and the risk for suicide might have biological as well as psychological causes.** Studies have found that some people who are depressed have altered levels of certain brain chemicals. Other studies have shown that aggressive and impulsive people who make violent suicide attempts have reduced amounts of seratonin, a key brain chemical.
- **A family history of suicide is a significant risk factor in a young person.** The family link might be because young people often identify with those closest to them and are likely to repeat their actions. However, there may be a genetic link as well, because biological relatives of a suicidal person are six times more likely to attempt or succeed in suicide than are adoptive relatives.

SOME NUMBERS: Increased awareness of the problem may have helped slow the rate of teen suicide in recent years. Still, the numbers show that teen suicide remains a very serious problem, and many think the actual number of suicides is two to three times higher than the statistics would indicate.

- **Suicide is the third leading cause of death among teenagers.** Among college students, suicide is the second leading cause of death. Studies show that about 12 of every 100,000 people between 15 and 24 committed suicide in 1983. Experts estimate that each year 5,500 teenagers commit suicide.

- **The incidence of suicide among people aged 15 to 24 has leveled off recently.** Even so, it has risen dramatically over the past 30 years. The rate went from 4.1 per 100,000 in the 1950s to 12.5 per 100,000 in 1980. Between 1970 and 1978, the suicide rate for those aged 15 to 24 rose 41 percent while the rate for the rest of the population remained stable.

- **White males have had the highest increase in suicide,** which rose 50 percent between 1970 and 1978. The increase for white females increased 12 percent. Recent studies show suicide among young blacks also is a major problem.

- **The ratio of male to female suicides is four to one.** However, young women attempt suicide four to eight times more frequently.

- **Reports of suicide "clusters," in which one suicide appears to trigger several others within a group such as a school or community, have increased.**

WHAT CAN YOU DO: Most people who are depressed or who are thinking about suicide don't or won't talk about how they are feeling. They feel worthless. They have no hope. They deny their emotions or think that talking about their emotions will be a "burden" on others because no one cares. Or they are afraid others will make fun of them.

That's understandable, because when someone mentions suicide, others may treat it as a joke or deny it. Those reactions only make the problem worse. So, **if a friend or relative brings up the subject, take it seriously and take some time to talk about it.**

- **Reassure that person** that he or she does have someone to turn to. Parents, friends, school counselors, physicians, teachers, or a brother or sister are probably all too willing to listen. It's just hard to let them know we want to talk about something as serious as our emotions.

- **Don't lecture or point out all the reasons a person has to live.** Instead, listen and reassure the individual that depression and suicidal tendencies can be treated. Depressive disorders respond readily to treatments such as psychotherapy or appropriate medication. Antidepressants can act within two to three weeks and often are used in addition to psychotherapy. Nearly 90 percent of all people suffering depression respond to these treatments.

- **You can find help by contacting your local chapter of the American Psychiatric Association,** which can suggest a psychiatrist who can help you. Psychiatrists are physicians who have special training in emotional and mental health. Other sources include your local mental health association, your family physician, a county medical society, a local hospital's department of psychiatry, a mood disorders program that is affiliated with a university or medical school, or a family service/social agency.

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*Good for parents.

March 1985

Provided by
The American Psychiatric Association
Division of Public Affairs
1400 K Street, N.W.
Washington, D.C. 20005

Senator SPECTER. Dr. Blumenthal, we welcome you here and we look forward to anything you might care to supplement what Dr. Silver has testified to.

Dr. BLUMENTHAL. Thank you, Senator. I will be very happy to answer any questions you might have.

Senator SPECTER. Dr. Silver, you have outlined a great many factors, some in technical terms, some not. In lay direct simple language to the extent you can, what is our best judgment as to the cause of teenage suicide?

Dr. SILVER. Perhaps I could start to answer and then ask Dr. Blumenthal to add.

We do not know the full answers yet. We have some ideas. We have some clues, but we do not have the answers.

Senator SPECTER. When you say you do not have the full answers, you have outlined a prodigious list of studies to be researched.

What research has been accomplished up to the present time?

Dr. SILVER. We do know that approximately 60 percent of the youth who successfully suicide have suggested evidence or definite evidence of a mental disorder, perhaps depression or the——

Senator SPECTER. Before you go on with the factors which lead to suicide, to what extent has the Federal Government or anyone really addressed this problem up to the moment?

How well have we done at looking at this important problem?

Dr. SILVER. The National Institute of Mental Health is funding research on the specific issue of teen suicide.

Senator SPECTER. For how long have you so funded it?

Dr. SILVER. The first grants began in the early sixties and the past year——

Senator METZENBAUM. Will you tell us something by the year 2020?

Senator SPECTER. Just a minute, Senator Metzenbaum. Let us proceed in order if we may.

Are adequate resources, in your judgment, being directed to the problem?

Dr. SILVER. I believe so.

Senator SPECTER. What is the resource allocation in a general way, Dr. Silver?

Dr. SILVER. The National Institute of Mental Health at the moment is funding about $1 million a year in research relating to the psychological, psychosocial, and biologic factors leading to teen suicide. We are also currently funding with the Centers for Disease Control epidemiological research, and research on the cluster phenomenon. And we are also working closely with the Office of Human Development Services.

Senator SPECTER. Before going on to what resources might be allocated for the future in terms of where we might be heading, what are the causes of teenage suicide as best we understand them at the moment based on the research to date?

Dr. SILVER. As I started to discuss earlier, researchers have studies suicides by meeting with family, friends, school personnel, and others to try to retrospectively sort out what happened. We find that up to 60% of individuals have had evidence of clinical depression, or have had evidence of a behavior or conduct disorder with impulsivity.

Senator SPECTER. These are behavior disorders with impulsivity?

Dr. SILVER. These are individuals who have emotional problems that are acted out in terms of behavior, such as getting into difficulty in school, delinquency, running away, and who also show evidence of difficulty in controling their aggressive behavior. We find that a percentage of these individuals have already been seeing mental health or health professionals. We are thus trying to sensitize mental health professionals and other health professionals to recognize and treat depression as well as other psychiatric disorders.

Senator SPECTER. What tips would you have for parents? What are the guideposts to look to that might be an indication of a suicide potential?

Dr. SILVER. Clearly, evidence of depression or of other types of control problems should be taken seriously. However, there are individuals who attempt or complete suicide where there is no evidence of a mental disorder. For these cases we are trying to find out what are the factors involved or what clues should be looked for.

The family history is of concern. There is a relationship between a family history of suicide and trying suicide.

Senator SPECTER. Dr. Silver, is that likely to be a genetic problem, a heredity problem or a suggestive problem? There has been some thought that when you talk about teenage suicides, you might be promoting the likelihood of a suicide, or where it exists in the family, it plants the idea as opposed to being something hereditary.

Dr. SILVER. You are raising all the questions we are concerned with. Is it something inherited through your genes? Is it the experience that you had, or a role model? We also are concerned about the impact of the media.

I started earlier by mentioning what we do know. There are other areas we do not know and where we need more research. One area is to gain a better understanding about individuals who show no evidence of mental disorder and still attempt or complete suicide. We are trying to understand what other factors could be picked up ahead of time. This information is in the brochures that will be put out by ACTION. The goal is to sensitize parents, friends, and school systems.

Senator SPECTER. Secretary Hardy, if funding were no objective, what would you like to see done in our national attack on the problem of suicide?

Ms. HARDY. I would like to see us have a significant public awareness campaign and a significant amount of work at the local level with a lot of community organizations in terms of awareness by parents, awareness by friends and how to better deal with young people who have problems. We have some very successful models out there. We have Parents Anonymous, which has the teen component, and those teens are helping other teens who have a potential of suicide. I think that has been very successful. There are a lot of things like that at the local level through the schools, and State legislation, such as that in California, that are out there that we think are good models and should be done in other parts of the country.

Senator SPECTER. Dr. Blumenthal, you are in charge of research at the National Institute. A two-part question.

Do you think adequate resources have been directed to this problem, and what would you like to see done for the future?

Dr. BLUMENTHAL. Well, I think suicide is a tragic human problem and it is the end point for many human problems. So I think when you ask what are the causes, I think there are many and that we need to continue to conduct research. I think that we have very recently developed some useful information about psychosocial factors, about psychiatric factors, and about biological factors involved in suicide. I think we need to do more studies that really will tell us more definitely about these factors. We also need to detect mental illnesses earlier in our young people and to prevent illnesses that may be associated with suicide.

I think that perhaps the media has given us a kind of false impression that suicide comes out of the air, and while for some number of people it may seem that there are no underlying causes apparent. But there may be tremendous stresses on-going and a youngster may feel that life is not worth living any more. I think there are many subgroups of youngsters who may decide to end their lives. There are youngsters who are very perfectionistic and families that very much need them to remain that way. There are youngsters who are, as Dr. Silver told us, because of impulsivity and aggressive behavior, more apt to get in trouble with the law, who run away, who get in trouble in school, and who are tremendous risks because they make people in their environment angry with them and yet these people do not recognize the signs of depression. There are many depressed youths.

In your State, for example, Senator, there are a number of centers at the Western Psychiatric Institute and the clinic at the University of Pennsylvania where research on depression in adolescence is going on that will add to our understanding of these risk factors. I really think that as we destigmatize mental illness in our country, and increase the public awareness that young people are suffering when their sleep gets disturbed, when appetite is disturbed, when they do not concentrate, when they lose pleasure in activities like school and sports that have usually given them enormous pleasure. We need to recognize the signs telling us when they get depressed and they may feel life no longer is worth living. If we can intervene earlier, and if we can translate our research into clinical practice and work with the communities and work with parents and volunteers who are interested in this problem, then I think we will have a much increased ability to prevent suicide in this country.

Senator SPECTER. Doctor, my question, the final one here, are we devoting adequate resources, Dr. Blumenthal, to this problem?

Dr. BLUMENTHAL. I think that Dr. Silver would need to answer that question.

Senator SPECTER. Well, I would be glad to have him answer it after you do. You are on the front line.

Dr. BLUMENTHAL. Well, I think that we are. I think that there are always other projects that can be done.

Senator SPECTER. Senator Simon.

Senator SIMON. Thank you, Mr. Chairman.

How does our suicide rate among teen-agers compare to other countries, Germany, Japan, Sweden?

Dr. BLUMENTHAL. We are somewhere in the middle. Countries like Czechoslovakia, Bulgaria have higher suicide rates. We also know that we are the only country where guns are the most prominent method of suicide.

Senator SIMON. What are some countries that have lower suicide rates?

Dr. BLUMENTHAL. England, for example, is really——

Senator SIMON. Are there any patterns? We are talking about 15 to 24 as a conglomerate group, but are 15-year olds more likely, 16-year-olds? Do we see a higher suicide rate among blacks than among whites?

There must be some patterns emerging in all of this.

Dr. BLUMENTHAL. We have some trends. I think others have addressed themselves to the fact that the national suicide rate has tripled in the past 30 years. The rate has stabilized at a relatively high rate for youth 15 to 24 years of age over the past 2 or 3 years. The bulk of suicides occurs in the 20- to 24-year-old age group, but the 15- to 19-year olds are also at risk. The rate in the 15- to 19-year-old group has risen and continues to rise somewhat, but we are seeing an alarming increase in youngsters aged 10 to 14.

One caveat, we must remember that many suicides are not reported because of the stigma attached, and because coroners do not report it as such because of the difficulties that parents and physicians have in calling it a suicide attempt or a suicide. We know that more young boys complete suicide at a ratio of four to one, and we know that young women attempt suicide four times as frequently as boys. There may be very different risk factors for suicide than those present in these two groups. In other words, the completers and attempters may be different and there may be different risk factors. We really need to develop ways of identifying those young people at highest risk to be able to prevent suicides.

That is what our work is aimed at at the National Institute of Mental Health when we fund research at centers such as those in Pennsylvania and in other parts of the country. We are really trying to be able to develop psychological tools, clinical tools, and biological markers for suicidal behavior. We also want to work with families because we consider that critical. You may be able to treat a youngster, you may be able to identify what the underlying problems are. But if you do not involve the family, and if the family is not sensitive, if the public is not sensitive to this tragic human problem and to the hurt and pain of the youngster, then the youngsters are going to go back into an environment where they may reexperience the problems that they are having.

Senator SIMON. Again on the subject of patterns can you spell out any ethnic or geographical pattern? In other words, in Illinois do you have patterns similar to Pennsylvania or Ohio. Is there anything that differentiates this problem at all?

Dr. BLUMENTHAL. Again, underscoring the fact that suicide completers and attempters may be different groups, with girls attempting four times more frequently, the West has a higher rate of suicide than does the Sun Belt. It is postulated that increased mobility in the society, the fact that perhaps there are not the kinds of family ties in people who have moved West, that this may be a risk factor, but that is something we need further research on.

Finally, in terms of method, guns are the method that most young people use. An alarming trend has been that since 1970 more young women are using guns as the primary method of killing themselves. Before that, they had been using medication. When people used medications or poisons they are less likely to succeed in completing suicide than when they use a very lethal thing like a handgun or a rifle.

Senator SIMON. Another question that any one of you may wish to address.

I was in the Chicago area where on the radio they say if you are considering suicide, call a certain number.

Are these programs effective? Can you tell?

Dr. BLUMENTHAL. We believe that suicide hotlines and prevention centers are important links for people who are distressed. These people will be able to call a number if they do not know where else to call, and that this would be a kind of lifeline. I think it is very important that suicide hotlines work with mental health professionals in getting that kind of input because when you are dealing with a potential suicide, you are dealing with an emergency in the sense that a person might die. I believe that the research that has been done evaluating suicide hotlines has not been definitive. It is not clear that suicide hotlines prevent suicide, but they may be helping people in distress.

I think we need more research on this and we hope to sponsor some research in this area.

What we do know is that in the literature on adults, at least 60 to 80 percent of the people who kill themselves have a serious level of depression. When we have major mood clinics that treat depression, that detect it early and treat it well, we know that the rates of suicide have been lowered. For example, at Columbia, the University of Tennessee and UCLA, 9,000 patients were followed for 9 years and they found only five suicides where they would have expected 55. So I am suggesting that there are many strategies to prevent suicide and we need to use as many as we can and we need to mobilize as many people as we can in the community, in the medical profession, among parents and all of you who have interest in this area. There are many strategies to do that.

From the research findings, we believe that one of the major prevention strategies is the early detection and treatment of depression and other behavioral disorders, and to also get the message to children that it is all right to fail sometimes, that they need not be so perfect. We believe that with this kind of sensitivity to the kinds of stresses and pain that young people have, and the kinds of emotional problems they may suffer, we will help to decrease the suicide rate in this country.

Senator SIMON. Thank you.

Thank you, Mr Chairman.

Senator SPECTER. Senator McConnell.

Senator MCCONNELL. Senator Simon asked if there are any geographical statistics in terms of suicide, and is it more likely to occur in one area of the country than the other. I think you indicated there were not.

Dr. **Blumenthal**. No, Senator. It is higher in the West and higher in the Sun Belt.

Senator **McConnell**. In terms of the life style of the children, is there more of a tendency for it to happen in cities as opposed to rural areas?

Dr. **Silver**. To explain the state of our art at this point, it is very difficult to get accurate data because the coroners, the medical examiners do not necessarily report all suicides or report them as suicides. By working with the Centers for Disease Control, we are trying to come up with a better definition. We are working with coroners and medical examiners to see if they would be more cooperative in terms of what they report, so we really only have the tip of the iceberg in terms of the data available.

We did a study of all reported cases recently, the Centers for Disease Control and National Institute of Mental Health and showed some of the trends that Dr. Blumenthal mentioned in terms of where it is located, raised a lot of good questions such as the ones you are asking, and they are now going back and reanalyzing these data to see if we can come up with more information.

Senator **McConnell**. The reason I asked is my State is a largely rural and small town State, and I have been fairly active in a variety of different children fields over the years. I do not recall this subject coming up anywhere except in Louisville, which is our largest city. That is the reason for my curiosity.

Dr. **Silver**. The data reported would suggest more urban than rural, but we do not have all the data yet.

Dr. **Blumenthal**. One of the odd things we have noted is that there was an outbreak in a rural community in Minnesota among youth last year. We also note that among farmers there has been an increase so it may be that wherever there is one of the important risk factors such as a humiliating life event which may precipitate a suicide or preçipitate a depression in young people or adults as well. We have seen that pattern in over 90 percent of the cases. An event such as an anticipated confrontation with a parent about truancy or failing at school, or not getting into the college of your choice or having——

Senator **McConnell**. One major feeling that precipitates the act?

Dr. **Blumenthal**. There seems to be something associated with the actual suicide completion. If you go back and do a psychological autopsy, go back and talk to the parents and talk to the friends, talk to the brothers and sisters and the high school teachers and you look at the medical records, and you try to put it all together, you find that everyone has a different opinion of what happened with the child and that you are able to reconstruct what was going on in their lives.

From these studies we found that for most of these kids, although there was that precipitating humiliating event, there was also something else that was going on in their life, that they had problems, they were disturbed, depressed or impulsively angry kids. Not all of them. Another group were very perfectionistic youngsters who really feel compelled to succeed and feel tremendous pressures to do well.

Senator McConnell. Is that more often the case than a child frequently experiencing setbacks?

Dr. Blumenthal. The current research suggests that those youngsters may be more in the minority, but——

Senator McConnell. Which?

Dr. Blumenthal. The perfectionists.

Senator McConnell. Are less likely to commit suicide?

Dr. Blumenthal. We do not have all the information, but what we do know is that there is a group of youngsters who are more perfectionistic. There seems to be less of them—in other words, the perfectionists make up less of the number of the completed suicides.

Senator McConnell. The perfectionists make up fewer of the completed suicides than those who suffer more of a series of humiliating setbacks?

Dr. Blumenthal. I am sorry. I must be confusing you.

In 90 percent of the completed suicides, there is some humiliating life event that precipitates the suicide, such as a breakup in a relationship, a confrontation for truancy or something that really was a blow to that young person's self-esteem.

Senator McConnell. I understand.

Is that likely to be the straight A student?

Dr. Blumenthal. Those are the minority of the youth suicides.

Senator McConnell. That is what I thought you said.

My other questions have to do with the rest of the family, other siblings.

Any indication that there is a likelihood that another sibling would do the same thing or is that usually the end of it for a family?

Dr. Blumenthal. We cannot talk about suicide without talking about the survivors, the people who are so hurt by the abrupt loss of someone they have loved, and the guilt that they may feel and the horror they may be experiencing about this tragedy. We know when a young person kills themselves in a family it may disrupt the whole family, and other youngsters in the family may be at risk because of, I think, the tremendous confusion which is created.

We also have information that indicates the risks where there is a family history of suicide. For example, if a father or mother or an uncle committed suicide, that a young person is at eight times greater risk of killing themselves than normal, and we do not know why. Dr. Silver addressed this. It may be through the phenomenon of identification that the young person has grown up in a family situation thinking about suicide as a possibility.

Senator McConnell. Do you have any statistics on siblings committing suicide?

Dr. Blumenthal. We do not. But we know they are at risk.

Senator McConnell. Secretary Hardy and I were talking before the hearing about the likelihood of divorce occurring after a suicide, and I wonder if any of you have any statistics on that?

Dr. Blumenthal. Again we do not have good statistics, but I believe that as in any other tragedy, for example, where you have the children or the parents of youngsters who die of cancer or leukemia, you see a lot of family stress. We hope during these times that with the care of family and friends, with community agencies intervening, with the help of mental health professionals, that families can become closer and try to understand this loss. I think it does put stress on families, and this is a question we really need to address, the question of what happens to survivors and how can we help.

Senator McConnell. We do not have statistics in either of those areas?

Dr. Blumenthal. No, unfortunately.

Senator McConnell. Thank you, Mr. Chairman.

Senator Specter. Senator Metzenbaum.

Senator Metzenbaum. Dr. Blumenthal, is there usually a threat in advance where the child tells his friends or her friends or the parents that I think I will take my own life? Is that common or is that a rarity?

Dr. Blumenthal. We believe that often a youngster gives a warning sign. They say something like I wish I were dead or, you will be better off without me. There have often been some signs, but families and friends often cover this up because they do not want to hear it and do not really listen. I think one of the things that we want to educate the public and mental health care professionals about is to really hear when a young person or an adult is feeling this kind of distress.

Also there have been other warning signs. Often a youngster is not sleeping well. They have lost their appetite. They are fatigued or they may become very agitated. They lose interest in things that usually give them pleasure. They withdraw from friends and family. There are sudden behavior changes, angry outbursts, and feeling an inappropriate sense of guilt or self-reproach such as saying I am not good enough, I am disappointing you.

So these things may be patterns, but I think because families do not know what to do, the public does not know where to turn, and because we still have a stigma about reaching out for help in this country, that these problems build up. I think that families again do not hear, and that is what all of us who are here would like to communicate, that health care professionals, mental health care specialists, the public and community agencies really need to join together to increase awareness about what these warnings signs are. We just need to hear them, recognize them and intervene.

It is important to communicate information to health and mental health clinicians and to the public on teen suicide. The NIMH is now preparing an updated monograph for the general public, a videodisc on the assessment of teen suicidal behavior for medical students and resident trainees, and a monograph on black suicide.

NIMH sponsored a workshop on preventive intervention research in December 1982 and will hold a series of knowledge transfer and research planning workshops over the coming year. A 3-day conference on suicide will be held in September cosponsored by NIMH and the New York Academy of Sciences. A conference for the general public and for professionals is planned for mid-June 1985, sponsored by the DHHS [OHDS] and implemented by ACTION.

Senator Metzenbaum. My understanding is that those signals are there. Now Dr. Silver has talked about all of the studies that have been made and are going to be made. You have just said we should be alerting the families and others, friends, as to these warning signals.

What is of greatest concern to me is the results of all the studies that have been made since 1960 and merely to learn that more boys are successful than young girls does not—and more young women make the effort but are not that successful, that there are more done in the West or in the South, and I have a feeling that we may be spending literally millions, I do not know how many tens of hundreds of millions we are spending in the three Government agencies represented here, or maybe there are two, and I am a little frustrated.

You say we want to alert. Why do we not? Why do we not?

Dr. BLUMENTHAL. Let me comment a little on research.

In the sixties there was some money that was put into establishing suicide prevention centers and suicide hotlines and doing early research in this area. There really was not very much research done after that early research. In 1981 NIMH established a suicide research unit. Since the establishment of that unit, we have been stimulating new research in the area of suicide and it is a very different kind of research from the earlier research. It is research that addresses very carefully issues of methodology because many of the early studies were very flawed.

Senator METZENBAUM. What?

Dr. BLUMENTHAL. Many early studies were flawed in terms of the fact that suicide is a very difficult problem to study, and that it happens fairly infrequently, although we are talking about it happening at a very high rate. But it is a hard subject to follow and it is hard to withhold an intervention, to withhold the treatment from someone who may be suicidal. But there is now a new generation of research since 1982 that is really starting to look at psychological factors and biological factors and is comparing those two control groups to people who do not have any problems so that we can scientifically compare various control groups.

Everyone says how do you distinguish between a youngster who is going through everyday adolescent turmoil and one who may be suicidal, but we have not had studies in the past that have addressed that issue. We do not currently have that knowledge but we hope that in the next few years we will have answers to this problem.

Dr. SILVER. I would like to give another example, Senator, where the research is just evolving.

Suicide, as we know, is a lethal disorder and, therefore, you cannot interview the person who committed suicide. You can try to learn from family, friends and others. If you go in and interview the family within the first 72 hours or a week, you are likely to get one set of responses. They are hurt, numb, there is no evidence he was other than a perfectly normal kid who suddenly committed suicide. You come back and see them in 6 months or 12 months or in some of the followup studies at 2 years, and you get new information each time. As the pain has lessened, they are better able to talk. In some cases, they will give you more facts. In other cases, with the passage of time and the need for denial to deal with the pain, they give you less information. So the problem we have is it is not like treating someone with an illness while they have the illness. The illness causes death so our research can only try to retrospectively understand, and the informants are not always able to give you all the information, and especially when we get to teen suicide which is perhaps even a more painful loss for parents, even though it is always painful.

Senator METZENBAUM. Let me ask either doctor, are there kinds of clinical studies which are made with young people generally, with large groups of young people trying to probe their thought processes, whether they have considered suicide as an alternative while they are living? Because I get the feeling that we are coming up with statistical data but, having said that, it does not seem to get us very far.

I noticed that Dr. Hardy indicates that every 90 minutes there is another teen-age suicide in this country. Did I read that correctly, that every 90 minutes another young person takes his or her life in this country?

Ms. HARDY. That is our understanding, yes, Senator.

Dr. SILVER. Senator, I think our research is multiple. It is not just the one you are mentioning. We are trying to understand what causes suicide in people who completed it.

There are also studies going on to study normal populations of children, of adolescents, of young adults, and in terms of how many of you have thought about suicide, how many of you considered it, how many of you actually tried it but did not tell anyone, and those data are just coming in.

We are also trying to do something before we have all the facts, and that is the preventive efforts you will have more about later this morning and other efforts to try and educate the public to make them more sensitive so they can respond, and also trying to work with the hotlines, with the crisis intervention centers to make them as maximally efficient as possible to prevent problems.

Senator METZENBAUM. How often do you have or does somebody have group sessions with young people, rap sessions, encounter groups where young people are told, or you try to get into their heads as to what they are thinking, not that that group is the challenge or the problem, but the fact is that maybe you can get some insights into it.

I still get the feeling, Dr. Silver and Dr. Blumenthal, that this is in your mind something that thinking about or looking at is a matter of we are going to find some further research. And what concerns me is the need for—certainly I am realistic enough to know you cannot press a button and solve a problem of this kind. Yet I am also concerned how much of the money is used for clinical studies and how much of it is used for laboratory studies and how much of it is used for statistical analysis, and how much money is spent in this area now by the government?

Dr. SILVER. The National Institute of Mental Health is spending approximately $1 million a year on the kinds of research we are talking about. However, at the same time, we are working very closely with ACTION, the group that is funded by the Office of Human Development Services, to develop what you are talking about.

Senator METZENBAUM. How much are they spending?

Ms. **Hardy**. Senator, we have, as I indicated earlier, a variety of programs that touch upon this. We have the runaway youth shelter program, and we see that many of our teens who run away also have a variety of other problems which can lead to suicide, so there are places like Huckleberry House in Columbus that are being funded to do these kinds of community-based programs you are talking about.

We also, as Dr. Silver indicated, are working with ACTION, and they are reaching out through their volunteer networks throughout the country. We anticipate a conference at the end of the summer.

Senator **Metzenbaum**. What kind of interreaction do you have with the suicide crisis centers that exist in the country? The Federal Government funds those or funds portions of those, do they not?

Dr. **Silver**. No, sir, any funding for service delivery is done under the block grant with the States, and perhaps when Charlotte Ross testifies later, she can tell you more about how these centers are funded. Some are by States, some by non-government groups. There are various models that are funding them. Our role is to be available to them or to help them, we hope, in the near future, to set up further studies with them.

Ms. **Hardy**. Senator, in addition, some of our dollars on the services side in terms of runaway youth money are linking with many of these teen suicide prevention centers at the local level, such as the one in Columbus, OH.

There are others around the country that we have just funded. In fact, this week $600,000 was funded to link our runaway youth shelters with the suicide prevention centers for teens at that local level.

Senator **Metzenbaum**. I am concerned, Dr. Silver and Dr. Blumenthal, that $1 million to provide research in this area is like a good tip at the Stork Club in the way we operate around Washington. It is such an insignificant amount that I just am shocked at its paucity.

Dr. **Silver**. This is money targeted for teen youth suicide. We are doing a lot of research around depression which will have a spinoff on this subject. There is research going on into biological factors, especially where we find an elevated Seratonin level with many successful or attempting suicidal individuals who have aggressive behavior. There is a lot of other research going on. The million dollars is only that which is targeted for the psychosocial, epidemiologic and other types of research we have talked about.

Senator **Metzenbaum**. Does any of that involve group research? In other words, encounter groups, talking with young people, meeting with them, trying to get them to explain why their colleagues and their friends think about committing suicide?

Dr. **Silver**. I cannot think of any specific ones on that.

Dr. **Blumenthal**. No; there are not. I think though that this is an activity that goes on at the local level in schools and so forth. I think what our hope would be is to work with some of these groups, with the suicide hotlines and crisis centers, and to encourage more of a collaboration through the American Association of Suicidology, between mental health professionals and these hotlines. Remember, the hotlines are pretty much manned by volunteers. If you think about the fact that suicide is a life-threatening problem, how many people who are untrained could really provide a helping hand, could tell someone where to go for help in that kind of crisis. I think that you really need to be able to turn to a lot of other sources for help and families need to learn to do that.

Senator METZENBAUM. Dr. Blumenthal, if you were asked, not necessarily before a Senate committee, how much money do you think we ought to have available to provide further studies and do that which has to be done in this area, would you answer a million dollars or would you answer some different figure?

Dr. Silver, you may answer.

Dr. SILVER. If I may preface my answer by the fact that suicide is a national problem, not necessarily a National Institute of Mental Health problem. We have to talk about what needs to be——

Senator METZENBAUM. Whose problem is it if not the National Institute's? Tell me who else should do the funding?

Dr. SILVER. I think a lot of other entities are involved, the Office of Human Development Services is involved. ACTION is involved. A lot of public and private sectors are helping to fund activities.

Senator METZENBAUM. Doctor, you are bouncing around with me. Tell me how much money you think the Federal Government ought to fund? They are not doing direct research in this area. Tell me how much money you think the Federal Government ought to put in this when every 90 minutes there is another youth suicide?

Dr. SILVER. I think you have to balance it off. At the moment we are talking about a very serious problem with 5,000 people a year. We could be talking about cancer, we could be talking about heart disease, and I think given the economic realities of the country at the moment that we are putting in an adequate amount of funds to try and solve this problem, trying to expand it by working with other components of the Government and outside of the Government.

Senator METZENBAUM. I am embarrassed for you for that answer, doctor. I think it is a terrible answer. I think if you had a real commitment to do something about this, you would agree that $1 million is a totally inadequate amount of money to be putting into this area. And to tell me about the economic realities—there could be 5,000 kids a year we lose, and you are telling me that $1 million is enough to put into research?

I remember when I was co-chairman of the National Citizens Committee for the Conquest of Cancer. We put $1 billion into cancer and I do not find any problem about that at all. Here we are losing 5,000 kids. There we lost about 350,000 or 400,000 Americans a year.

Dr. SILVER. Senator, you are picking on one thing, the amount of money being spent on youth suicide. Remember again the millions of dollars we are spending to study basic psychiatric disorders like depression that contribute to it, biological factors research that is going on, the research that is going on in the Alcohol and Drug Institute, the relation of substance abuse to suicide, the work that is being done in the Centers for Disease Control, the other studies that are being done. You are picking one topic which is specifically targeted to study the psychological and social issues related to teen suicide.

Senator **Metzenbaum**. Indeed I am. All the rest of it has to do with special emphasis. Your direction is ostensibly in the field of child suicide.

And I want to say, Mr. Chairman, that I am not exactly sure when this will come before us for authorization, but when it does, I would certainly move that we substantially increase the funding in this area. I just cannot believe that $1 million for child suicide investigation is enough, and I hope you would join with me.

Senator **Specter**. Thank you, Senator Metzenbaum.

I start off as I did on the questions of what are the resources, where are we heading, what is adequate? What I would ask you to do, Dr. Silver, Dr. Blumenthal, and Secretary Hardy, between now and the time that there is a markup in the Appropriations Committee, which I think is probably going to deal with it most directly, with the Subcommittee on Health and Human Services where I also sit, I would like to see you come to grips with some of the practical answers as to how your research would interact with the crisis prevention centers. There has been a certain amount of frustration by everybody on the panel this morning, and that is the purpose of a legislative hearing, to have our ideas tested against what you are doing on the research and/or in the executive branch. But Senator McConnell is concerned about the absence of statistics and Senator Simon is looking for some patterns, and I am looking for some hard indicators. And the testimony you have given is as scientifically accurate as you can provide, but it seems to me that the problem has gone on so long and there has been so much research that we have come to a point where you ought to say what does our research tell us as we can best generalize, and how can we use our research to date with the crisis intervention centers, what can we do to advise parents about the danger signals? Perhaps it boils down to saying on a public announcement teenagers, if you feel depressed, or if you feel like you are going to take your own life, for God's sake, tell somebody, and then to the parents or the teachers, if somebody has brought you a danger signal or has told you something, let us get somebody into the picture who can provide psychiatric help. But the pace is less than a snail's pace

I think Senator Metzenbaum is correct about that. I think that is the sense as to where we are going.

At this juncture I would like to put into the record a letter from the superintendent of schools of Philadelphia about the TALKLINE[1] which has been put into operation there, and that suggests the time has come for some of the practical approaches and the generalizations as best we can deal with it. The scientific research is indispensable, and I applaud the work you are doing, and I know that it is difficult to pick a figure out of the air. And I suppose, Dr. Silver, you would not turn down $1 billion if David Stockman would authorize it. But we understand the constraints that you operate under, but you would like to pursue it in the future.

I agree with Senator Metzenbaum that we ought to follow this more closely in this subcommittee.

Senator **Metzenbaum**. Dr. Silver, in David Stockman's world, anything up to $50 million is not even an item in the budget, so you can get up to another $48 million and you will never even come to his attention.

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[1] See appendix page 78.

Dr. SILVER. Senator, the material that you want, translating what we already know into something that is practical and useful, is exactly what ACTION will be doing under the funding from the Office of Human Development Services. These are the pamphlets that will be coming.

Senator SPECTER. That defines what ACTION is doing, but I am interested in what NIMH is doing.

Ms. HARDY. That is the research, Senator, and I think what you have been talking to us about is ACTION, those activities and the kinds of things that come out of the research and how best we can use our research, and I think we have given a lot of good examples and can provide you with a lot more that really show what we are doing at the community level. And it is not just us. It is a lot of people.

Senator SPECTER. ACTION has dealt with Dr. Silver and Dr. Blumenthal. Maybe they have gotten more specifics than what we have, but what I am urging, and we have got to move on to the next panel because time is flying, is to see to the extent it is possible that you relate your very good research work with some of the practical aspects of it.

Dr. Blumenthal, you have one last comment?

Dr. BLUMENTHAL. While research goes on, we have many activities that try to translate the results of that research into clinical practice. We work with communities, with the media, we publish information, and we work with our scientists to disseminate information about depression and about youth suicide. I think that there are a number of activities underway and certainly many more that we would like to do and could be doing, but I think this——

Senator SPECTER. Tell us about those. Tell us about the ones you would like to do and what you think it would cost us to do it.

Dr. BLUMENTHAL. I think there are a large number of research questions to be answered.

Senator SPECTER. I do not mean for you to tell us now, but tell us between the time we are going to deal with it on appropriations.

We thank you very much.

[Subsequently, Dr. Silver furnished the following information:]

As you have asked, I would like to suggest my best judgment regarding an expanded budget for NIMH research on youth suicide. I have broken down the needs into three areas. The total is $2 million. (This amount includes the $1 million currently targeted for teen suicide research.)

RESEARCH—$1.8 MILLION

To expand current research on psychosocial, biological, risk factor research;
To develop research focusing on teen suicide;
To develop longitudinal studies of suicide attempters;
To expand preventive intervention research (evaluation of hotlines, crisis centers);
To evaluate effectiveness of educational programs; and
To develop new intervention strategies.

KNOWLEDGE TRANSFER—$0.1 MILLION

To hold research planning and clinical intervention workshops/conferences; and
To develop literature on current knowledge/state of the art for lay public, policy makers, health/mental health professionals.

INTERAGENCY/ORGANIZATIONAL ACTIVITIES—$0.1 MILLION

To expand collaborative research with CDC; and

To develop collaborative activities with American Association of Suicidology and other organizations.

Senator SPECTER. We would like to move on to the next panel of Dr. Pamela Cantor, president of the American Association of Suicidology, Chestnut Hill, MA; Heidi Bilodeau, Boston, MA; and Charlotte P. Ross, cochairperson of the National Committee for Youth Suicide Prevention and director of the Youth Suicide and Crisis Prevention Center of San Mateo County, CA.

Welcome and, Dr. Cantor, we would like to begin with you.

If you would summarize, all statements will be made a part of the record, and to the extent you can summarize, leaving the maximum time for questions and answers, we would appreciate it.

STATEMENTS OF PANEL CONSISTING OF DR. PAMELA CANTOR, PRESIDENT, AMERICAN ASSOCIATION OF SUICIDOLOGY, CHESTNUT HILL, MA; HEIDI BILODEAU, BOSTON, MA; AND CHARLOTTE P. ROSS, COCHAIRPERSON, NATIONAL COMMITTEE FOR YOUTH SUICIDE PREVENTION, DIRECTOR, YOUTH SUICIDE AND CRISIS PREVENTION CENTER OF SAN MATEO COUNTY, CA

Dr. CANTOR. Thank you, Senator Specter.

It is a pleasure to be here. If I might I would like to take a moment before turning to my prepared remarks, to answer two excellent questions that were asked before.

A question was asked "Where does the United States stand in terms of our statistics on youth suicide?" There are World Health Organization statistics to show that Switzerland is the highest rated in terms of youth suicide followed by Austria, Canada, and the United States. We are fourth. In Switzerland, it is 29 youngsters out of every 100,000 who commit suicide. In the United States, is approximately 12.3 out of every 100,000. The lowest rate is in countries such as Israel and Egypt, which have a rate of approximately .03 percent per 100,000.

The second question concerned the geographic distribution of adolescent suicide. The increase in adolescent suicide has been primarily a Western phenomenon. We have tremendously high rates in States, such as Nevada—27 per 100,000—and low rates in the Eastern Seaboard States such as New York, New Jersey, Massachusetts and Connecticut. It seems that suicide is largely a problem of isolation and it is largely a rural rather than an urban phenomenon. It is possible that this is related to the fact there are fewer social services and more isolation in these Western States.

I am Pamela Cantor, president of the American Association of Suicidology. The association is a national organization of approximately 1,000 members representing psychiatrists, sociologists, psychologists and others. It was organized in 1967 to study the causes and prevention of suicide.

It has been mentioned that 5,200 adolescents kill themselves every year. It has not been mentioned that approximately 500,000 adolescents attempt suicide every year. This means that one adolescent commits suicide every 90 minutes in the United States. Perhaps even more startling is the statistic that one adolescent attempts suicide every minute in the United States.

This is a national health problem of epidemic proportions that is selectively affecting our youth.

In the last 20 years, the mortality rate for every age group in the United States has improved except for the group of young people, ages 15 through 24. The mortality rates for this age group have increased. The two types of death which are largely responsible for this increase are suicide and homicide. Both of these have doubled in the past 20 years, and both reflect social factors more than any other cause of death.

What can we do, as you have so astutely asked, to reduce these alarming statistics?

I have been asked to make specific recommendations for intervention which would have an immediate impact. Clearly we need research. We need research into biological and affective disorders, and epidemiological research. But we cannot wait for another 20 years for these answers.

I have been asked to make two specific recommendations to you based on my 16 years of research, treatment and public education in the field. One recommendation is to conduct school programs in suicide prevention for students and teachers, and community education for parents. Educational intervention is difficult to evaluate because of the absence of data. However, over a period of years, it appears that education would have a great potential for decreasing self-inflicted mortality. I use the analogy of sanitation and its effect on infectious diseases. More lives have been saved by preventive sanitation measures than by antibiotics. Based upon studies of the effect of public education in the areas of child abuse, discrimination and drunk driving, it is estimated that self-inflicted mortality for children and adolescents could be reduced by about 20 percent through public education.

The second recommendation, and perhaps the most important strategy in the fight to stop teen-age suicide, is the limitation of the availability of lethal agents.

The increase in suicide among young people can be accounted for almost entirely by firearms. Guns now account for more suicides than all other methods combined. Sixty-five percent of all teen suicides are committed with firearms. An environmental risk reduction strategy would call for the decreased availability of handguns to children and adolescents. Some 25 million households have handguns and one-half of these keep their handguns loaded. Adolescents are impulsive, and having a loaded handgun in the house is an invitation to disaster.

Mandatory safety training programs and public education in the dangers of handguns in the home would not resolve the underlying problems of self-esteem and depression which drive our young people to suicide, yet it would result in fewer deaths. Here I use the analogy of mandatory seatbelts. Seatbelts do not make people better drivers, but they do improve the chances of surviving a collision.

The estimates we have are that 65 percent of teen suicides are caused by guns. Epidemiological studies estimate that 70 percent of those victims would not have obtained handguns if there were safety gun regulations, and some 50 percent of these individuals would choose other means, and thus we estimate reduction in firearm accessibility could save the lives of approximately 20 percent of our youngsters. One example involving the cooperation of police and parents towards education with regard to handgun safety has been developed by the Handgun Information Center.

Senator SPECTER. Dr. Cantor, your entire statement will be made a part of the record. If you can summarize, we would appreciate it.

Dr. CANTOR. What we have learned with this is when highly lethal methods of suicide are made less available, there is evidence to show that teens do not switch to other means. When the English converted their highly lethal coke gas as a means of home heating to nonlethal natural gas, the suicide rate dropped 33 percent. This low rate has not come up again despite economic unrest in England.

Poisoning, usually with prescription medicine, is the second most commmon method of lethal suicide, accounting for 11.3 percent of all suicides. The availability of lethal drugs could be limited by restricting the number of tablets permitted for each prescription. This kind of registration on sedative and hypnotic drugs is thought to be largely responsible for the decline in suicide rate in Australia in the 1960's and 1970's. In addition, the tricyclic antidepressants could be sold with an emetic or antidote. If the teen overdosed and changed his mind, or was found, an antidote could be given and a life could be saved.

The cost of suicide in terms of mortality, the effects on lives and the cost of health care are great. Numerous factors are associated with the problem of suicide, and each suggests a specific set of interventions. The majority of risks for teenagers, however, center on two areas: the cultural pervasiveness of violence and negative social factors such as emotional neglect and stress. The interventions which would appear to have the greatest impact on youth suicides are the limitation of the availability of firearms and medication together with public education programs.

[The prepared statement of Dr. Cantor follows:]

PREPARED STATEMENT OF DR. PAMELA CANTOR

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE. I AM DR. PAMELA CANTOR. PRESIDENT OF THE AMERICAN ASSOCIATION OF SUICIDOLOGY.

THE AMERICAN ASSOCIATION OF SUICIDOLOGY (AAS) IS A NATIONAL ORGANIZATION OF APPROXIMATELY 1000 MEMBERS REPRESENTING PSYCHIATRISTS, SOCIOLOGISTS, PSYCHOLOGISTS AND OTHERS, WHICH WAS ORGANIZED IN 1967 TO STUDY THE CAUSES AND PREVENTION OF SUICIDE. THE AAS TRAINS PERSONNEL IN SUICIDE PREVENTION AND INTERVENTION, CERTIFIES SUICIDE PREVENTION CLINICS ACROSS THE COUNTRY, AND DISSEMINATES INFORMATION ON SUICIDE PREVENTION THROUGH ITS QUARTERLY JOURNAL.

EACH YEAR, 5,200 ADOLESCENTS COMMIT SUICIDE IN THE U.S. AND 500,000 ATTEMPT SUICIDE. THIS MEANS THAT ONE ADOLESCENT ATTEMPTS SUICIDE EVERY MINUTE, AND ONE ADOLESCENT TAKES HIS OWN LIFE EVERY NINETY MINUTES. THIS IS A NATIONAL HEALTH PROBLEM OF EPIDEMIC PROPORTIONS WHICH IS SELECTIVELY AFFECTING OUR YOUTH.

OVER THE PAST 20 YEARS, THE MORTALITY RATE FOR EVERY AGE GROUP IN THE U.S. HAS IMPROVED EXCEPT THE GROUP OF AMERICANS AGED 15 TO 24.

THE TWO TYPES OF DEATH WHICH ARE LARGELY RESPONSIBLE FOR THIS INCREASE ARE SUICIDE AND HOMICIDE. BOTH OF THESE HAVE DOUBLED IN THE PAST 20 YEARS AND BOTH REFLECT SOCIAL FACTORS MORE THAN ANY OTHER CAUSE OF DEATH.

WHAT CAN BE DONE TO REDUCE THESE ALARMING STATISTICS?

ONE POSSIBILITY IS TO CONDUCT SCHOOL PROGRAMS IN SUICIDE PREVENTION FOR STUDENTS AND TEACHERS, AND COMMUNITY EDUCATION FOR PARENTS. EDUCATIONAL INTERVENTION IS DIFFICULT TO EVALUATE BECAUSE OF THE ABSENCE OF DATA. HOWEVER, OVER A PERIOD OF YEARS, EDUCATION WOULD APPEAR TO HAVE A GREAT POTENTIAL FOR DECREASING SELF-INFLICTED MORTALITY. I USE THE ANALOGY OF SANITATION AND ITS EFFECTS ON INFECTIOUS DISEASES: MORE LIVES HAVE BEEN SAVED BY PREVENTIVE

SANITATION THAN BY ANTIBIOTICS. BASED ON STUDIES OF THE EFFECT OF PUBLIC EDUCATION IN THE AREAS OF CHILD ABUSE, DISCRIMINATION, AND DRUNK DRIVING, SELF-INFLICTED MORTALITY FOR CHILDREN AND ADOLESCENTS COULD BE REDUCED BY ABOUT 20% THROUGH PUBLIC EDUCATION.

THE MOST IMPORTANT STRATEGY IN THE FIGHT TO STOP TEENAGE SUICIDE IS THE LIMITATION OF THE AVAILABILTY OF LETHAL AGENTS. THE INCREASE IN SUICIDE AMONG YOUNG PEOPLE CAN BE ACCOUNTED FOR ALMOST ENTIRELY BY FIREARMS.

GUNS NOW ACCOUNT FOR MORE SUICIDES THAN ALL OTHER METHODS COMBINED: 65% OF ALL TEEN SUICIDES ARE COMMITTED WITH FIREARMS. AN ENVIRONMENTAL RISK REDUCTION STRATEGY WOULD CALL FOR THE DECREASED AVAILABILITY OF HANDGUNS. SOME 25 MILLION HOUSEHOLDS HAVE HANDGUNS AND ONE-HALF OF THESE KEEP THEIR HANDGUNS LOADED. ADOLESCENTS ARE IMPULSIVE; HAVING A LOADED HANDGUN IN THE HOUSE IS AN INVITATION TO DISASTER.

MANDATORY SAFETY TRAINING AND PUBLIC EDUCATION ON THE DANGERS OF HANDGUNS IN THE HOME WOULD NOT RESOLVE THE UNDERLYING PROBLEMS OF SELF-ESTEEM AND DEPRESSION WHICH DRIVES OUR YOUNG PEOPLE TO SUICIDE, YET IT WOULD RESULT IN FEWER DEATHS. HERE I USE THE ANALOGY OF MANDATORY SEATBELTS: SEATBELTS DO NOT MAKE PEOPLE BETTER DRIVERS, BUT THEY DO IMPROVE THE CHANCES OF SURVIVING A COLLISION.

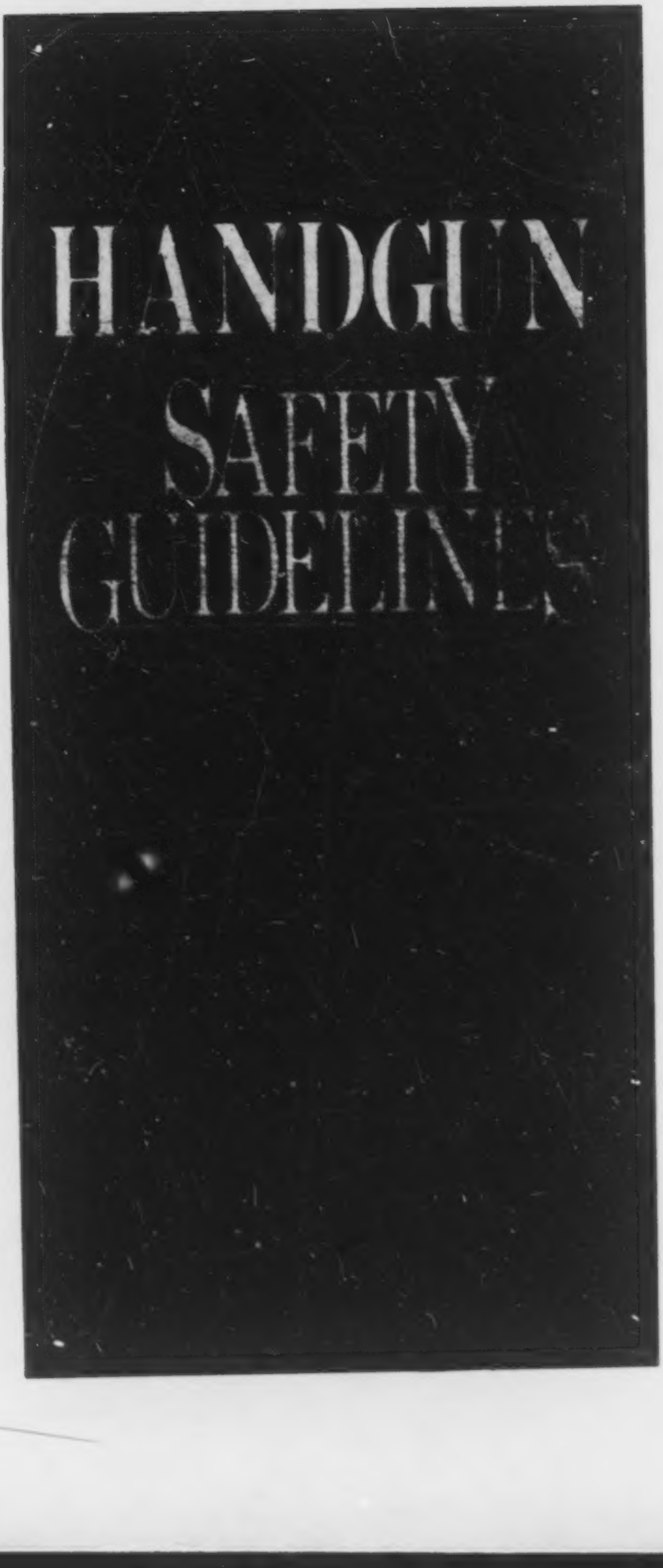
CURRENTLY, 65% OF TEEN SUICIDES ARE CAUSED BY GUNS; EPIDEMIOLOGICAL STUDIES ESTIMATE 70% OF THOSE VICTIMS COULD NOT OBTAIN HANDGUNS IF THERE HAD BEEN HANDGUN REGULATIONS; AND SOME 50% OF THESE INDIVIDUALS MIGHT USE ANOTHER METHOD. THUS WE ESTIMATE REDUCTION IN FIREARM ACCESSIBILITY WOULD SAVE THE LIVES OF APPROXIMATELY 20% OF OUR YOUNGSTERS. ONE PROGRAM INVOLVING THE COOPERATION OF THE POLICE AND PARENTS TO REDUCE FIREARM ACCESSIBILITY, HAS BEEN DEVELOPED BY THE HANDGUN INFORMATION CENTER. THIS PROGRAM IS DESIGNED TO EMPHASIZE COMMON-SENSE SUGGESTIONS REGARDING THE STORAGE, MAINTENANCE AND HANDLING OF HANDGUNS AND COULD REDUCE THE NUMBERS OF HANDGUN ACCIDENTS AND SUICIDES EACH YEAR. ATTACHED TO THIS TESTIMONY IS A COPY OF "HANDGUN SAFETY GUIDELINES," A BROCHURE DEVELOPED BY THE CENTER FOR THIS PURPOSE.

WHEN HIGHLY LETHAL METHODS OF SUICIDE ARE LESS AVAILABLE. THERE IS EVIDENCE TO SHOW THAT TEENS DO NOT NECESSARILY SWITCH TO OTHER MEANS. WHEN THE ENGLISH CONVERTED THEIR HOME HEATING GAS FROM DEADLY COKE GAS TO LOW-LETHALITY NATURAL GAS, THE SUICIDE RATE DROPPED 33%. THIS LOW RATE HAS REMAINED CONSTANT DESPITE THE BLEAK ECONOMIC PICTURE IN ENGLAND, WHICH WOULD ORDINARILY BE EXPECTED TO LEAD TO AN INCREASE IN THE SUICIDE RATE.

POISONING, USUALLY WITH PRESCRIPTION MEDICINE, IS THE SECOND MOST COMMON METHOD OF SUICIDE, ACCOUNTING FOR 11.3% OF ALL SUICIDES. THE AVAILABILITY OF LETHAL DRUGS COULD BE LIMITED BY RESTRICTING THE NUMBER OF TABLETS PERMITTED FOR EACH PRESCRIPTION. THIS KIND OF LEGISLATIVE RESTRICTION ON HYPNOTIC AND SEDATIVE DRUGS IS THOUGHT TO BE LARGELY RESPONSIBLE FOR THE DECLINE IN SUICIDE RATES IN AUSTRALIA IN THE 1960S AND 70S. IN ADDITION, THE TRICYCLIC ANTI-DEPRESSANTS COULD BE SOLD WITH AN EMETIC OR ANTIDOTE. IF A TEEN OVERDOSED AND CHANGED HIS MIND, OR WAS FOUND, AN ANTIDOTE COULD BE GIVEN AND A LIFE COULD BE SAVED. THE PROJECTION IS THAT THIS WOULD SAVE APPROXIMATELY 3% OF TEENAGE SUICIDES PER YEAR.

THE COST OF SUICIDE IN TERMS OF MORTALITY, THE EFFECTS ON LIVES AND THE COST OF HEALTH CARE ARE GREAT. NUMEROUS FACTORS ARE ASSOCIATED WITH THE PROBLEM OF SUICIDE. EACH SUGGESTS A SPECIFIC SET OF INTERVENTIONS. THE MAJORITY OF RISKS FOR TEENAGERS, HOWEVER, CENTER ON TWO AREAS: THE CULTURAL PERVASIVENESS OF VIOLENCE, AND NEGATIVE SOCIAL FACTORS SUCH AS EMOTIONAL NEGLECT AND STRESS. THE INTERVENTIONS WHICH WOULD APPEAR TO HAVE THE GREATEST IMPACT ON YOUTH SUICIDE ARE THE LIMITATION OF THE AVAILABILITY OF FIREARMS AND MEDICATIONS TOGETHER WITH PUBLIC EDUCATION PROGRAMS.

I WOULD NOW LIKE TO INTROCDUCE HEIDI, A YOUNG WOMAN WHO FIRST ATTEMPTED SUICIDE AT AGE 15 BY TAKING AN OVERDOSE OF PILLS. SHE WANTED TO DIE, AND WOULD HAVE USED A HANDGUN WERE IT AVAILABLE. FORTUNATELY, SHE USED A METHOD THAT ALLOWED ROOM FOR RESCUE.



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GARY P. HAYES
EXECUTIVE DIRECTOR

Dear Friend:

As police officers, we live each day with handguns. Before we were issued our handguns we were carefully trained and made to understand the serious responsibility of handgun ownership and the dangers of our handguns falling into the wrong hands.

A handgun is a magnet for children, who too often mistake it for a toy. The result each year is hundreds of needless deaths and injuries.

Due in part to their accessibility, more than 100,000 handguns are stolen every year from law-abiding citizens. These handguns are often used to commit further crimes by the burglar or resold on the black market.

Few realize that handguns in the wrong hands kill as many Americans each year as do drunk drivers. As police, we are doing all we can to curb drunk driving. Likewise, a handgun should be taken away from someone who is under age, mentally disturbed or under the influence of alcohol or drugs.

Many handgun tragedies could be prevented if additional safety precautions were taken by handgun owners. If you are considering purchasing a handgun or already own one, we strongly recommend you take the time to read carefully the information contained in this brochure. It may save the life of someone you love.

Sincerely,

Lt. Anthony Chiesa

Lt. Anthony Chiesa
Chicago Police Department

Lt Harris

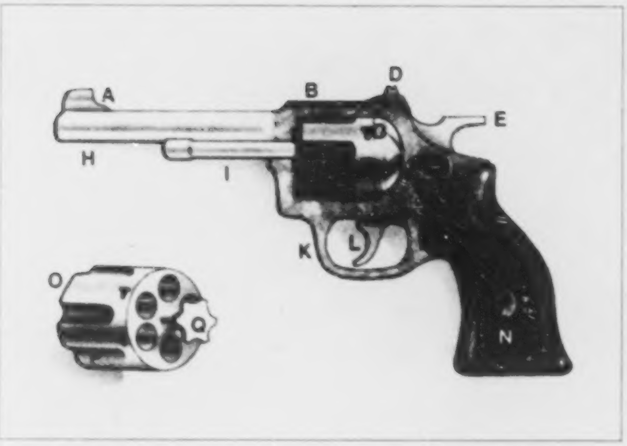
Lt. Jack Harris
Tucson Police Department

Lt Michael McCampbell

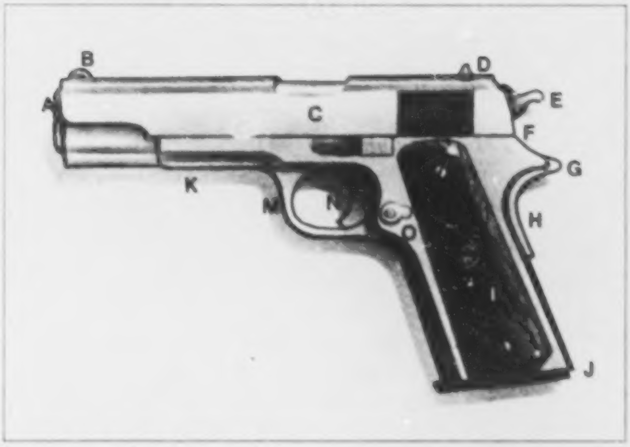
Lt. Mike McCampbell
Arlington County (Va.)
Police Department

Robert R. McDonnell

Sgt. Robert McDonnell
Baltimore County
Police Department



A Front Sight
B Top Strap
C Cylinder Bolt Notch
D Rear Sight
E Hammer
F Cylinder Release
G Backstrap
H Barrel
I Ejector Rod
J Cylinder
K Trigger Guard
L Trigger
M Frame
N Stock or Grip
O The Cylinder
P Cylinder
Q Ejector



A Barrel and Barrel Bushing
B Front Sight
C Slide
D Rear Sight
E Hammer
F Safety Catch
G Tang
H Grip Safety
I Stock or Grip
J Main Spring Housing
K Frame
L Slide Stop
M Trigger Guard
N Trigger
O Magazine Catch
P Magazine

Owning a Handgun

The decision to own a handgun assumes you are prepared to undertake full-time responsibility for your weapon's safety and security. You must protect yourself and your family members against misuse of the handgun by anyone who is either incompetent or unqualified to handle the weapon. In particular, you must secure your handgun from theft and misuse by children.

If you have a handgun, you must also personally assume full-time responsibility for its safe handling and use, making sure you know how it works and how to maintain it. You must also be aware of the circumstances in which you may legally use a handgun for self-defense.

If you have a handgun you should understand that it is a lethal weapon, capable of inflicting death and disabling injury on living targets. If not treated with utmost caution and safety, it can accidentally discharge and result in tragic consequences for you and your family. Studies show that accidental handgun deaths in the home occur most often while playing with the gun, examining or demonstrating the gun and cleaning or repairing the gun.

In the pages that follow, we describe step-by-step precautions that you can take to protect you and your family members from being accidentally killed or maimed by your handgun. It is your responsibility to put these safety rules into practice.

Before we begin, you should know the parts of your pistol or revolver, as illustrated on the preceding page.

Storage

As a handgun owner, safe and secure storage is one of the most important responsibilities that you assume. Only you and your spouse should be aware of where your weapon is permanently stored. It should not be within sight or reach of children, or accessible to burglars. Specifically we recommend that you:

- Store your handgun unloaded and uncocked in a securely locked container.
- Store your handgun and its ammunition in separate locations.
- Do not store your handgun among your valuables, such as jewelry or silver.
- Do not store your handgun in a bedside table or under your mattress or pillow.
- Child-proof your revolver by placing a padlock around the top strap of the weapon or by securing a trigger lock.

- Child-proof your semi-automatic handgun by removing the magazine, disassembling the frame from the slide and magazine or securing a trigger lock.
- Always carry with you on your key chain the keys that open both the locked container that stores your handgun and its padlock or trigger lock.
- If you go on vacation, consider additional safekeeping measures for your handgun while you are away.
  Be certain to check with your police department about the laws governing transportation of handguns outside the home.
- Store ammunition in a locked container, away from heat or moisture.
- Never throw out ammunition in the trash.

Maintenance

Another important responsibility you undertake, if you choose to own a handgun, is to clean and maintain your weapon on a monthly basis. Proper functioning and safety of a handgun can be impaired by rust, dirt or improper maintenance procedures. As with any high quality piece of precision equipment, your handgun must be cared for according to the manufacturer's directions. In addition, we recommend that you:

- Always check twice prior to cleaning your handgun to make sure it is unloaded.
- Clean your handgun after each use according to the manufacturer's directions and with the proper equipment.
- Clean your handgun alone and in a safe place.
- Check your handgun every month for proper functioning, either by dry firing in a safe location or target shooting at a pistol range.
- Store your handgun in a location that protects it from excessive temperature changes or moisture.
- Wrap your handgun in a silicone cloth or moisture-barrier paper. Never wrap it in a newspaper, sock or leather holster — these attract moisture.
- Do not make repairs on, or modifications to, your handgun. These should only be made by the manufacturer or a qualified gunsmith. Note that any modification to your handgun may be potentially dangerous and may void your warranty.

Training

If you own a handgun you have a responsibility to receive proper training on how to use and maintain your weapon. Certified and reputable handgun safety courses and instructors are often sponsored by state and local gun clubs.

Any safety course should present relevant information as well as ample opportunities for you to practice firing and cleaning your handgun. Specifically, the course should:

- Provide information describing the parts and workings of the handgun, how to load and unload it, and the location and operation of its safety features.
- Teach specific procedures for proper care, cleaning and maintenance of the handgun.
- Describe safety rules for handgun home storage and use, while transporting the weapon, and while on the range.
- Specify the legal requirements and moral considerations related to handgun ownership, use, possession, sale and transfer.
- Teach the principles of marksmanship: trigger control, grip and sight alignment and sight picture.
- Provide opportunities for you to fire a minimum of 400 rounds of ammunition at the pistol range.
- Require you to pass a written test demonstrating your comprehension of course material.
- Require you to pass a performance test demonstrating your ability to handle, use and clean the handgun properly.

Handling and Use

If you own a handgun, you must be absolutely certain that it is unloaded whenever you or a family member handles it. Further, it should never be displayed at a social gathering or made a topic of conversation. It should never appear accompanying the use of drugs or alcohol. We recommend that the following safety rules be strictly enforced:

- Always treat every handgun as if it were loaded.
- Give your handgun to someone only if you verify that it is unloaded and the cylinder or action is open. Take a handgun from someone only after you verify that it is unloaded and the cylinder or action is open.

- Check and see that a handgun is unloaded immediately after you pick up the weapon.
- Check that the barrel is clear before you load or fire your handgun.
- Load your handgun only if and when you intend to fire it.
- Assume your handgun's safety devices will fail.
- When handling or cleaning your handgun, never leave it unattended — it should be in your view and under your supervision at all times.

Legal Requirements

Laws regulating handguns are often complex and vary greatly among the states. If you are a handgun owner, it is your responsibility to learn about all relevant aspects of federal, state and local firearms laws. Specifically you should know:

- Legal requirements pertaining to handgun purchase, transfer, possession, licensing and registration.
- Legal requirements regulating carrying and transporting a handgun.
- Legal requirements defining the appropriate use of deadly force by citizens. In some states, for instance, deadly force can only be used after all other defensive remedies have been tried and the armed citizen believes he is in imminent danger of the use of deadly force against him.
- Civil penalties for death or injuries even if you were justified in firing your handgun.
- Civil penalties for deaths and injuries if someone other than yourself abuses your handgun.

If you are unable to answer these questions, you may want to reconsider your decision to own a handgun; and also enroll in a handgun safety training course. ▶

Handgun Owner's Checklist

- What are the legal requirements for the purchase, possession, registration and transfer of a handgun in your community?

- What is your handgun serial number? Where is it recorded?

- Under what circumstances can you legally use a handgun in the protection of your life or the life of another?

- What kind of handgun training have you received? What did you learn about handgun safety, use and maintenance?

- Were you required to pass a written test at the conclusion of the course?

- Were you required to demonstrate safe handgun handling and cleaning techniques?

- What have you done to "child-proof" your handgun?

- How and where is your handgun stored?

  ____

  Is it secured by a lock? ______________________

  Where is the key? ______________________

  Who else knows about where it is stored? ______________________

  Is it unloaded? ______________________

  Where is the ammunition? ______________________

- When did you last change or replace your ammunition?

  ____

- When was your handgun last inspected and cleaned?

  ____

- If you own a revolver, identify its cylinder, trigger guard and hammer:

  ____

- If you own a semi-automatic pistol, identify its slide, safety catch and magazine catch:

  ____

- Name the safety features on your handgun:

  ____

- Explain how they function:

  ____

  ____

  ____

  ____

This brochure is published by The Handgun Information Center ("The Center") as a service to the public. It was developed and written under a grant to the Police Executive Research Forum ("PERF"). The Center and PERF disclaim any and all liability arising from publication or distribution of this brochure. Due to the danger of handguns, The Center and PERF advise extreme caution in their safekeeping and use.

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1400 K Street, N.W.
Suite 500
Washington, D.C. 20005

Senator SPECTER. Thank you, Dr. Cantor.

We would like now to hear from Heidi Bilodeau, and we very much appreciate your being with us. We understand that you will be providing testimony about an attempted suicide yourself, and we understand the difficulty of your coming forward to provide this testimony. And we thank you for being here.

You may now proceed.

STATEMENT OF HEIDI BILODEAU

Ms. BILODEAU. I appreciate being asked.

Senator SPECTER. Could you pull the microphone very close so we can hear everything you say. Even a little more.

Ms. BILODEAU. I appreciate being asked here today to speak. When asked what brought me to actively seek suicide to end my emotional pain, I would have to mention the two major sources of my despair. One was the conflict of adolescence, and having been brought up with strong morals and ethics, I felt unequipped to handle the waves of people who did not think similarly. And I berated myself for my naivete. The other source was the death of a friend at age 14 whom I had had a disagreement with earlier that week, and thus the combination of loss and guilt became overwhelming.

When these emotions continued, they became self-hatred. The self-destructiveness began then with razor blades. I stayed in my room most of the time writing dirge, which is depressive poetry, and planning that day when I would take those pills and never again feel the pain of war in my soul.

At age 15, I took my first overdose. I had accidentally OD'd once before. It kept me semiconscious for 2 days, but I was unsuccessful. So, after another slash of the wrists, I was sent to a State hospital for children. Then, 6 months later, I was sent to where I referred to as the "warehouse," a State mental institution where, at the age of 16, I would be supposedly helped by the understaffed mental health system and utilized role models such as the 40-year-old man who paced up and down the halls, a woman with slashed tracks the length of both arms, and other refugees of the outside world.

After a year, I signed myself out, but it took much longer to get the internal stuff right, to feel good about what I had to offer as a person. There were three drug overdose attempts made by me. I took increasing amounts each time, but God had plans for me, which I am discovering each and every day as a Christian.

The rage which consumed my entire being could have easily directed me toward a deadly weapon but, fortunately, my parents possessed no guns. It is difficult to explain to someone who has never felt that depletion of life force how a person can want to do mercy killing on themselves. I believe it to be instinctual when you hurt. Your automatic response demands you cease the pain. Suicide is just that.

Dr. Pam Cantor often uses the light at the end of the tunnel. She knows from her working experience that the pain is temporary. The dark tunnel in one's mind does, indeed, have a light, which she sees. But as a suicide person, I did not. Those years of darkness ended for me and have allowed me the opportunity to utilize the pain in a positive way. So many others never waited out that little while longer to see the other side.

So, in closing, I must reiterate that if there had been a gun available, I would now be a statistic.

Thank you.

Senator SPECTER. Thank you very much, Ms. Bilodeau.

Ms. Ross, thank you for joining us and we look forward to your testimony.

STATEMENT OF CHARLOTTE P. ROSS

Ms. ROSS. Thank you, and I just want to comment that when the testimony is through, I, too, will look forward to answering some of the questions that were raised to the previous panel, as I think both Dr. Cantor and I can add some information.

I was asked to comment on some of the legislative activities that are going on regarding youth suicide. I would like to point out that our laws are created for the purpose of protecting and preserving what we hold to be most sacred. Most often they are created as a response to a current and obvious need; you all have presented statistics that show you are well aware of the magnitude of the problem and the need to act.

The need for action is both current and urgent. I appreciate also your interest in and concern for the problem, and I appreciate the time you have made available to me today to share with you the possibilities I and many others see for responsible local legislation which can encourage and facilitate appropriate efforts for prevention of youth suicide.

I would like to comment briefly first on the relationship of legislation to suicide, where it has been, where it is, and where I see it going in the future.

The concept of legislation to prevent suicide is not new. For many years, as you are probably aware, it was felt that suicide could be controlled by punishing the act. Suicide, therefore, was declared a crime and subject to punishment by law. But the effect of those laws was not the prevention of suicide. Instead, they added to the burden already felt by those experiencing suicidal feelings. Suicidal persons were forced into greater secrecy and isolation, and additional barriers were placed between them and what they most needed, the help of caring others.

In addition, suicide attempts or deaths were often disguised as accidents by survivors who feared legal repercussions as well as societal stigma.

Perhaps the impact of this stigma can be illustrated by a brief example of the origin and nature of these laws. American criminal penalties for suicide derived from the common law of England. At one time, English common law punished the crime of suicide by requiring burial of the remains of the deceased at a crossroads with a stake impaling the body, a stone placed over the face, and the amputation of the hand that committed the self-murder

In addition, the King confiscated the suicide victim's property. Forfeiture of property reflected the King's view of suicide as contrary to his interests in preserving the lives of his subjects. I think you should note it was not until 1961 that the English Parliament abolished the crime of suicide by statute, realizing that such penalties served more to punish and stigmatize the surviving families of suicides rather than as a deterrent.

In our country in recent years, most of these punitive laws have been removed. To commit suicide is no longer a crime in any of the 50 States, although it was at one time in all, and only 2 States, Oklahoma and Texas, still consider it a crime to attempt suicide. However, although these laws have been removed, their legacy remains with us, and it is this we must also combat.

Today, a new and far more humane approach is evolving, paving the way for the new kinds of legislation affecting not only the victims and survivors of suicidal death, but also who have felt the despair and hopelessness of suicidal depression.

In 1983, senate bill 947, the Youth Suicide Prevention School Program, was introduced in California. This legislation was the first in the country designed to prevent youth suicide and to extend help to potential suicide victims. Although it addresses only one aspect of the problem, the prevention of youth suicide through education and training in the schools, it was viewed as an important beginning step.

The legislation was drawn from the experience of two local programs. Although evaluation of the effectiveness of these programs has been limited—school suicide prevention programs have not been included among the areas selected by most researchers for study and evaluation—the model developed was shown to be significantly effective in increasing the identification of high-risk students and in effecting referrals to treatment. Thus, it was selected as appropriate and responsive to the demand of citizens for action to turn around the rising tide of young deaths and offer assistance to those who were at risk.

As you also are aware, the California legislation was followed by similar action in other States. Florida passed senate bill 529, mandating the development of a comprehensive program of youth suicide prevention in the schools. New Jersey has a bill that is through the senate, and a number of other States are in the various stages of developing local legislation that is responsive to their needs.

I would like to take a moment to add my appreciation to you for Senate Joint Resolution 53. It will do more than call attention to a month of youth suicide recognition. It increases public awareness and action.

As to what can be done now, it is my belief that this Nation can indeed turn back the tide of youth suicide. Obviously, I believe it will take not just the efforts of legislators or of educators, parents, researchers, or mental health professionals. It will take all of us working together and responding to a wide range of needs.

States, such as California, are now developing such an approach. Components include supplementing the educational programs for youth with those designed to increase general public awareness. This includes developing a statewide clearinghouse for information and data.

Second, specialized programs for relevant groups, which includes supplementary training to be available to mental health professionals to increase their expertise in dealing with suicidal youth and survivors. And, last, but clearly not least, special attention is being given to the juvenile justice system. Juvenile detention facilities and runaway shelters serve youth who have suffered a variety of losses, who often have inadequate support systems and, therefore, are particularly at risk. Suicide prevention in any institutional setting is a humanitarian effort, but it is also a self-protection measure. A suicide or attempted suicide within such a facility, besides being a tragic event, has definite legal ramifications. An increasing number of wrongful death suits initiated by concerned third parties has been experienced by juvenile detention facilities throughout the country. There exists a pressing need for special training for facility staff regarding the identification, assessment and management of suicidal youth and for the review and possible revision of protocols.

Senator SPECTER. Ms. Ross, your full statement will be made a part of the record. So, to the extent you could summarize, we would appreciate it.

Ms. ROSS. Let me just conclude it then with one final comment.

One of the widespread myths about those who are suicidal was reflected in a popular newspaper column recently. For some reason, the writer seemed to imply some of us can cope with life and some cannot. Those who cannot will commit suicide, and there is not much we can do about it. But suicide is not a loser's way out, nor are suicidal feelings indicative of a person who will never make it. Through this current suicide epidemic, we are not only losing far too many of our young, we are often losing those who have the most to bring to our society.

I would like to close today with a note written by a young man who wanted to give up on life. He expressed feelings felt by many young people and also in a way many of the comments made by Heidi.

As he pondered suicide, this is what he wrote:

> I am now the most miserable man living. If what I feel were equally distributed to the whole human family, there would not be one cheerful face on Earth. Whether I shall ever be better, I cannot tell. I awfully forebode I shall not. To remain as I am is quite impossible. I must die to be better, it appears to me. I can write no more.

To the benefit of our entire Nation, this young man reached out for help and he found it. His name was Abraham Lincoln.

Thank you very much.

Senator SPECTER. Thank you very much, Ms. Ross.

Ms. Bilodeau, would you pull the microphone closer?

Having made the attempts at suicide yourself, as you have described them, if you were to give advice to some teenagers, and you were a teenager when you tried to suicide, give advice to somebody who felt like taking their own life, what advice would you give to that person?

Ms. BILODEAU. To make the effort not to isolate one's self because there are resources in hotlines, in community centers, in crisis centers that are there for the asking. But, one, people have to be aware of those resources. But on a very small level, if you just tell one person, and even if that person who is suicidal asks for you not to tell anyone, do it because you are saving their life, and that exceeds their personal wishes because once they get to see the other side of it, it is so much easier.

Senator SPECTER. So your advice to someone who is thinking about suicide would be——

Ms. BILODEAU. Just reach out to one person.

Senator SPECTER [continuing]. Reach out to one person, and whom would you suggest that person be? A parent, a teacher, a friend?

Ms. BILODEAU. Whomever it is easier for you. I had a friend who is a teacher who was there for me, and she was invaluable. So whomever the suicidal person is comfortable with and trusts, that is the person.

Senator SPECTER. So the suicidal person should reach out to a friend and that friend then should get help for that suicidal person?

Ms. BILODEAU. As someone else said, the uses of hotlines, they are very important, but it is only a beginning step. You have to follow through with professional people like Pam.

Senator SPECTER. Based upon your own experience, if the suicidal person is not going to reach out for help, what should a parent look for to try to figure out when a child might be inclined to suicide?

Ms. BILODEAU. I believe other people have mentioned some of the signs: the withdrawals. It is hard for adolescents because you are going to have erratic moods and that is just part of the adjustment process. I would probably say though the withdrawing is the thing that was indicative in my case. I cannot say of everyone. Maybe extreme anger. Just extremes in a major way.

Senator SPECTER. What would you say that the government should be doing by way of funding or resources to try to deal with this problem of suicide among teenagers?

Ms. BILODEAU. Well, I believe in commonsense methods myself and in local like community resources. The gentleman, Mr. Metzenbaum, who was sitting there, getting it to a person-to-person level and the government through other agencies can help provide funds for community centers, and also work with the State to provide more direct resources because if they are there, they will be utilized.

Senator SPECTER. Dr. Cantor, let me ask you that question. If you were to make a recommendation to this Subcommittee as to what we should be doing to bring more resources to bear on this problem, what would you say?

Dr. CANTOR. I believe I have answered that in my brief comments in my statement. I think there is a three-pronged approach that is necessary to make an immediate impact. One is to increase education available through the media and through schools to parents, teachers, the community and children. And the second is to reduce the availability of lethal means, and that those two factors will have a greater impact on reducing the suicide rate among adolescents than else that we have done in the past number of years.

Senator SPECTER. How would you respond to that question, Ms. Ross? What would you say if you were to direct our attention to the most narrow area possible? What is the most important?

Ms. ROSS. I think you have got an excellent example that was given to you before, and I would like to see much more of that. Really, the cooperative effort between HHS, ACTION, and the private sector in bringing together the resources of this country, in mobilizing them all toward youth suicide prevention in very pragmatic ways, in working collaboratively is, indeed, impressive. And I think it will become more impressive.

I think further actions along this line so that we use all our resources to their maximum will give us the range of help we need. I would like to see much more done.

Senator SPECTER. Thank you all very much. We very much appreciate your being here.

The Subcommittee will be pursuing the matter further. The hearing is concluded.

[Whereupon, at 12:15 p.m., the subcommittee adjourned, to reconvene at the call of the Chair.]

APPENDIX

STATEMENT

OF

DR. CONSTANCE E. CLAYTON
SUPERINTENDENT OF SCHOOLS
SCHOOL DISTRICT OF PHILADELPHIA

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to share with you information related to the institution of TALKLINE, a citywide, crisis hotline for children.

In Philadelphia, as in other areas across our nation, we have been deeply concerned by the ever-increasing numbers of adolescent suicides. We are keenly aware that:

--The suicide rate among adolescents has tripled since 1950.
—Suicide is the second leading cause of death for young people.
--For every completed adolescent suicide, there are at least fifty to one hundred attempts.
--The suicide of a teenager is devastating for family, friends, school and community.

Figures released for Philadelphia show that over a four year period, from 1981-1984, approximately two hundred suicides were completed by individuals between the ages of ten and twenty-four, reflecting 25 percent of all suicides during that period.

During the summer of 1984, an elementary school student in subdistrict six of the School District of Philadelphia committed suicide, and reports of suicidal attempts and gestures were heard among children of all ages.

Official School District reports have cited attempted suicides, such as: "on 2-25-85, ______________ took forty to fifty unknown pills at home. Later, in school, complained that she was feeling ill and was taken to a local hospital for treatment. Her family believes she will try again." ______________ is thirteen years old.

"on 2-28-85, ______________ took eight unknown pills at school this morning in a suicide attempt. A suicide note was found by a teacher, and the student was hospitalized." ___________'s note states, in part, "I'm fifteen, I live in ______________, Philadelphia, I'm a very troubled person who never talks about his problems... It's all over, I took eight pills of some unknown source and I pray it ends now."

More recently, in mid-March, 1985, a student threatened suicide in a letter written to the Superintendent of Schools, Dr. Constance E. Clayton: "... If you don't help me, I'll commit suicide in one of your schools."

Fortunately, for the three young people cited in the preceding paragraphs, intensive treatment, therapy and family counselling have been undertaken. However, we recognize that many more troubled youngsters need our help.

Although there is no definitive explanation of the causes of teenage suicide, researchers have identified several categories of risk factors: family conflicts and a chaotic family environment; pressures to succeed; increased availability of drugs and alcohol; depression; the sudden death or loss of a loved one; lack of structure in one's life; disintegration of traditional support systems; isolation in an increasingly mobile society; and others.

These risk factors can be found throughout the general population. Teenage suicides occur among all social classes, economic groups, races and religions. Although communication can be a first step in helping such troubled young people, tragically, discernible warning signs of distress often go unheeded. Through TALKLINE, we in Philadelphia hope to provide to students the opportunity for that first step, communication, and the subsequent, necessary intervention and follow-up.

The tragic suicide of an elementary school child during the summer of 1984 provided the impetus for TALKLINE. A concerned school principal in subdistrict six contacted Intercommunity Action, Inc. (INTERAC) to ascertain whether assistance could be obtained for those families who are reluctant to seek mental health services for themselves or their children in the more traditional ways. INTERAC is a human service agency in Northwest Philadelphia, which has provided an ever-increasing range of mental health, mental retardation, aging, and substance abuse services since its incorporation in 1969. Although its primary responsibility is to the 70,000 people who reside within its catchment area, INTERAC has a well-defined system of access to emergency and crisis intervention services throughout the City.

For many years, INTERAC has been working with school personnel in subdistrict six to address the emotional needs of children and families. This collaboration has taken the form of consultation, referral, and follow-up and has resulted in a mutually supportive relationship between the two when problems arise.

Representatives of the subdistrict six office and INTERAC began to meet and plan for a volunteer hotline which would be available and responsive to these children and families. With the school providing volunteer recruitment, publicity and education about the availability of this service, INTERAC would provide the training of volunteers and professional clinical support needed for implementation. This partnership between INTERAC and the schools, providing telephone access to caring, listening, support and referral, would relieve children and families of the previously identified barriers to seeking help.

Within Philadelphia and the Delaware Valley other citywide hotline services are available though none specifically address the needs and concerns of children. In contacting each of these providers, including CONTACT, TEL-E-HELP, WOAR and CAPE, all indicated a perceived need for a hotline service targeted toward children. The rate of utilization of these hotlines, without breakdowns by age of caller, ranged from 19,000 to 67,193 calls per year. A hotline for children, initiated January 15, 1985 in Syracuse, New York, experienced a utilization rate of 225 calls during its first two weeks of operation. Calls to a Philadelphia citywide hotline are anticipated to at least triple this figure.

The concerns and needs of callers are expected to range from minor upset to life threatening, keeping in mind, that for children, even the minor upset can take on crisis proportions. From the six year old frightened by noises in an empty house to the sixteen year old considering downing a bottle of pills after a breakup with her boyfriend, the hotline can serve as a lifeline, a way for each child to be heard, supported and given needed care. In a similar way, parents are expected to use the hotline to cope with overwhelming situations which may be frightening for them to discuss with authority figures.

The Scott Paper Company, with its pledge of more than $20,000.00 to help fund TALKLINE, agreed to take a leadership role in attracting additional corporate support for continued funding of this critical endeavor. Through the initiative, interest and support of Scott Paper, we hope to maintain TALKLINE for the youth of Philadelphia in the months and years ahead.

As a result of the discussions between INTERAC and School District officials in subdistrict six, a meeting was scheduled with the Superintendent of Schools, who agreed with the concept and who encouraged the implementation of a youth hotline which would be made available to all youth in the City of Philadelphia.

In addition to the cooperation of INTERAC and the Scott Paper Company, we have been most fortunate for the cooperative efforts of the Philadelphia Archdiocese, the Philadelphia Police Department, Philadelphia City Mental Health Agencies, members of the Media, parents and members of the Philadelphia community.

TALKLINE volunteers receive thrity-five hours of training by INTERAC staff, and during its hours of operation, volunteers are supervised by professional, clinical staff. Although our primary rationale for the establishment of TALKLINE focuses on suicide, we recognize that callers may wish to discuss other areas which are problematic. Consequently, the training program for volunteers covers a wide array of topics, including: orientation; initial screening of volunteers; skill and information training; interviewing; listening; problem solving; decision making; relationship building; discipline; drugs/alcohol; depression/suicide; sexuality.

It should be noted that the screening process for volunteers is most carefully and intensively conducted to assure that the quality of care and service provided to young people in need is of the highest caliber.

A network has been established to provide referral services through local community mental health agencies, school principals and counselors and the Philadelphia Police Department, as deemed necessary, depending upon the nature of specific calls received.

During its first week of operation, April 15 to 19, 1985, fifty-five calls were received by TALKLINE, from youth between the ages of six to twenty-four. Of these, three calls were potential suicides. In each situation, appropriate intervention has been taken to diffuse the callers' anxieties, and follow-up measures have been implemented to provide ongoing counselling through school and mental health agencies.

As the dissemination of information regarding TALKLINE reaches a wider audience, we anticipate a significant increase in the number of calls. In fact, on Thursday, April 25, 1985, a distribution of flyers to school students announcing the availability of TALKLINE resulted in more than 120 calls between the hours of 2:00 and 9:00 p.m.

We are most appreciative of members of the Philadelphia community for their interest and support in this endeavor. We are particularly indebted to Intercommunity Action, Inc. for its cooperation in developing the proposal for TALKLINE and the responsibility INTERAC has undertaken in the training of volunteers and operation of TALKLINE, and to the Scott Paper Company for its contributions, assistance in planning, financial support, and for its initiative in encouraging corporate support for TALKLINE.

Although we represent diverse entities, our singular goal is the preservation of the healthy minds and bodies of our young people now, and for future generations--to save a single life would be more than enough.

References Cited:

1. Adolescent Suicide: A Review
Sheldon P. Wayman, D.O.

2. "Dealing with the Crisis of Suicide"
Calvin J. Frederick and Louise Lagul

Public Affairs Pamphlet No. 406A
New York, New York

3. Intercommunity Action, Inc.
TALKLINE Fact Sheet; Proposal Abstract

4. "Surviving: Handbook on Teenage Suicide Prevention"
ABC Theater Presentation
February, 1985

SCHOOL DISTRICT OF PHILADELPHIA/INTERAC
TALKLINE Fact Sheet

During the summer of 1984, an elementary school student of the Philadelphia public schools committed suicide. This tragic event precipitated a series of meetings between personnel of the School District of Philadelphia and members of Intercommunity Action, Inc. a human service agency in Northwest Philadelphia. As a result of these meetings, a proposal was developed to initiate a citywide, child targeted suicide hotline. In addition to the cooperative efforts of the School District and INTERAC, the Scott Paper Company agreed to provide a startup grant of more than $20,000.00 and other resources for the hotline, and has taken a leadership role in encouraging other corporate sponsors of the hotline.

On April 15, 1985, TALKLINE, the citywide suicide prevention hotline for adolescents in Philadelphia, was initiated. According to INTERAC, which operates the hotline, in the first week of operation, three potential suicide calls were received. In each case, the situation was diffused and follow up measures have been taken. These three cases are convincing proof that our efforts have not been in vain, for if we save the life of one child, we have succeeded.

United States Senate

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WASHINGTON, D.C. 20510

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30 April 1985

Honorable Arlen Specter
Chairman
Subcommittee on Juvenile Justice
327 Hart Senate Office Building
Washington, D.C. 25010

Dear Arlen:

I commend you for conducting a very insightful hearing on the tragedy of youth suicide. Today's witnesses forcefully detailed the scope of the national problem of young Americans killing themselves.

As a follow-up to the testimony on the legislative initatives presented by Charlotte D. Ross, I thought that it might be useful to place in the record examples of state legislation and initatives. Accordingly, I would ask that copies of this letter; a bill entitled the "Alabama Youth Emotional Guidance and Suicide Prevention Act," which is now pending in the Alabama State Legislature and a proclamation issued by Governor George Wallace designating June 1985 as "Youth Suicide Prevention Month" be placed in the appendix to the hearing record.

Thank you for your assistance in this matter.

Sincerely,

Jerry

Jeremiah Denton
United States Senator

JD:hj
Enclosure

STATE OF ALABAMA

PROCLAMATION

BY THE GOVERNOR

WHEREAS, the youth of society represent the hope for the future; and

WHEREAS, the rate of youth suicide has increased more than threefold in the last two decades; and

WHEREAS, over five thousand young Americans took their lives last year, many more attempted suicide, and countless families were affected; and

WHEREAS, youth suicide is a phenomenon which must be addressed by a concerned society; and

WHEREAS, youth suicide is a national problem which can only be solved through the combined efforts of individuals, families, communities, organizations, and government to educate society:

NOW, THERFORE, I, George C. Wallace, Governor of the State of Alabama, do hereby proclaim June, 1985, as

YOUTH SUICIDE PREVENTION MONTH

in Alabama.

GIVEN UNDER MY HAND, and the
Great Seal of the Governor's
Office at the State Capitol
in the City of Montgomery on
this the 28th day of March,
1985.

George C. Wallace

GEORGE C. WALLACE
GOVERNOR

LRS85-129:1/23/85

H. 284 By White (G), Buchus, Zoghby, Davis, Biddle, Bowling, Box
Rice, Gaston, Grouby, Hammett, Adams and Beers
R1 2/5/85
RFD Health

Jefferson Jefferson Mobile Jefferson Jefferson Cullman Mobil
Lee Mobile Autauga Chilton Covington Russell Jefferson

SYNOPSIS: This bill establishes the "**Alabama Youth Emotional Guidance and Suicide Prevention Act**". The department of education and the rehabilitation and crippled children's service of said department and the department of mental health shall administer the provisions of this act. It provides for the cooperation of the departments of education, mental health, pensions and security, youth services, and law enforcement agencies in the identification, intervention and prevention of youth suicide as well as public awareness and education. It provides for local participation by local community agencies, local tax forces and local school boards of education in order to provide a student services program, including guidance and psychological services. It makes certain training required for holders of teachers' certificates and requires curriculum changes.

A BILL
TO BE ENTITLED
AN ACT

To establish the "Alabama Youth Educational Guidance and Suicide Prevention Act," to prescribe that the department of education, the rehabilitation and crippled children's service of said department, and the department of mental health shall administer the provisions of this act; to prescribe that the said departments, various law enforcement agencies, local community agencies, department of youth services, the department of mental health and local task forces and local school boards of education shall cooperate in providing a student services program and in the identification, intervention and prevention of youth suicide, including guidance and psychological services; to provide for certain training for holders of all classes of teachers' certificates whether provisional or otherwise; to provide for public awareness education; and to provide further for a student curriculm to include related training or courses in emotional guidance and suicide prevention.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. This act may be cited as the "Alabama Youth Emotional Guidance and Suicide Prevention Act."

Section 2. The incidence of teenage suicide has escalated rapidly over the past 10 years. The rate of suicide among teenagers has increased 122 percent during the past 20 years, and suicide has been the third leading cause of death of persons age 15 through 24 during the past 10 years. The impact of the incidence of teenage suicide has caused the legislature to determine that the prevention of suicide by youths is a priority of this state. The legislature makes the following findings and declarations:

(1) A statewide program to promote the positive emotional guidance of youths, and to prevent suicide by youths is essential to address the continuing problem of youth suicide in this state.

(2) The emotional problems of youth often are compounded by other problems such as drug abuse, alcohol abuse, and school and family problems.

(3) A suicide prevention program for Alabama youths can best be accomplished by coordinating the educational

N. 284

programs at the state and local levels with the community suicide prevention and crises center agencies. It is the intent of the legislature that cooperation among these groups shall be a major component in its effort to achieve the successful prevention of youth suicide.

(4) Crises intervention and suicide prevention for the purposes of this act shall center on:

(a) Better detection by students, teachers, and family members of the signs of emotional distress in a youth that might result in suicide.

(b) Defined responsibility for school counselors.

(c) Timely referral of potential suicide victims to community professionals as needed.

(d) Cooperation between school and nonschool professionals.

Section 3. (a) The department of education and the rehabilitation and crippled children's service shall develop a state plan for the prevention of youth suicide and shall submit the plan to the speaker of the house representatives, the president of the senate, and the governor no later than the first day of the next regular session of the legislature 1986. The department of education shall participate and fully cooperate in the development of the state plan at both the state and local levels. Furthermore, appropriate local agencies and organizations shall be provided an opportunity to participate in the development of the state plan at the local level. Appropriate local groups and organizations shall include, but not be limited to, community mental health centers, the school boards of the local school districts, the advocacy committees, private or public organizations or programs, including parent teacher associations, with recognized expertise in working with children who are emotionally distressed and with expertise in working with the families of such children, law enforcement agencies, and the circuit courts. The state plan to be provided to the legislature and the governor shall include, as a minimum, the information required of the various groups in subparagraph (b).

(b) The development of the comprehensive state plan shall be accomplished in the following manner:

(1) The department of education, the rehabilitation and crippled children's service and the department of mental health shall establish an interprogram task force comprised of representatives from each and from the department of youth services, the state health department, the department of pensions and security and the department of public safety. The interprogram task force shall be responsible for:

a. Developing a plan of action for better coordination and integration of the goals, activities, and funding pertaining to the state plan for the prevention of youth suicide to be developed by the department of education and rehabilitation and crippled children's service and mental health department to maximize staff and resources at the state level. The plan of action shall be included in the state plan.

b. Providing a basic format to be used by the service districts of the departments in the preparation of local plans of action to provide for uniformity in the service district plans and to provide for greater ease in compiling information for the state plan.

c. Providing the service districts with technical assistance in the development of local plans of action, if requested.

d. Examining the local plans to determine if all the requirements of the local plans have been met and, if they have not, informing the service districts of the deficiencies and requesting the additional information needed.

e. Preparing the state plan for submission to the legislature and the governor. Such preparation shall include the collecting of information obtained from the local plans, the cooperative plans with the department of education, and the plan of action for coordination and integration of activities of the department of health, department of mental health, and rehabilitation and crippled children's service into one comprehensive plan. The state comprehensive plan shall include a section reflecting general conditions and needs, an analysis of variations based on population or geographic areas, identified problems, and recommendations for change. In essence, the plan shall provide an analysis and summary of each element of the local plans to provide a statewide perspective. The plan shall also include each separate local plan of action.

f. Working with the specified state agencies in fulfilling the requirements of this paragraph.

Section 4. The department of health, the department of mental health, the rehabilitation and crippled children's service and the department of education shall work together to develop ways to inform and instruct appropriate district school personnel in all school districts in the detection of conditions which indicate youth suicidal tendencies and in the proper action that should be taken when there is reason to suspect that a student is contemplating suicide. The plan for accomplishing this end shall be included in the state plan.

Section 5. The department of public safety, the department of mental health, the department of health, the rehabilitation and crippled children's service shall work together to develop ways to inform and instruct appropriate local law enforcement personnel in the detection of youth suicidal tendencies, and in the proper action that should be taken to prevent suicide.

Section 6. Within existing appropriations, the department of health, rehabilitation and crippled children's service shall work with other appropriate public and private agencies to emphasize efforts to educate the general public about the problem of youth suicide and ways to detect the warning signs that indicate a youth is planning to commit suicide, and in the proper action that should be taken to prevent a suicide. The plan for accomplishing this end shall be included in the state plan.

Section 7. The department of education, the rehabilitation and crippled children's service, the department of health and the department of mental health, shall work together on the enhancement or adaptation of curriculum materials to assist instructional personnel in providing instruction through a multidisciplinary approach on the identification, intervention, and prevention of youth suicide. The curriculum materials shall be geared toward a program of instruction at the 9-12 grade level. Strategies for requiring all school districts to utilize the curriculum are to be included in the comprehensive state plan for the prevention of youth suicide.

Section 8. The department of education shall develop audio-visual and other training materials relating to suicide prevention and positive emotional guidance and shall distribute such materials to each school district for required in-service training for all teachers and administrators.

Section 9. Each service district of the department of health, the department of mental health, and the rehabilitation and crippled children's service shall develop a plan for its specific geographic area. The plan developed at the district level shall be submitted to the interprogram task force for use in preparing the state plan. The service district local plan of action shall be prepared with the

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involvement and assistance of the local agencies and organizations listed in paragraph (a) and representatives from those departmental district offices participating in the prevention of youth suicide. To accomplish this, the district administrator in each service district shall establish a task force on the prevention of youth suicide. The district administrator shall appoint the members of the task force in accordance with the membership requirements of this section. In addition, the district administrator shall ensure that each subdistrict is represented on the task force; and, if the district does not have subdistricts, the district administrator shall ensure that both urban and rural areas are represented on the task force. The task force shall develop a written statement clearly identifying its operating procedures, purpose, overall responsibilities, and method of meeting responsibilities within the provisions of this act. The district plan of action to be prepared by the task force shall include, but shall not be limited to:

a. Documentation of the magnitude of the problems of youth suicide in its geographical area.

b. A description of programs currently serving suicidal or emotionally upset youth and their families and of programs for the prevention of youth suicide, including information on their impact, cost-effectiveness, and sources of funding.

c. A continuum of programs and services necessary for a comprehensive approach to the prevention of youth suicide as well as a brief description of such programs and services.

d. A description, documentation, and priority ranking of local needs related to youth suicide prevention based upon the continuum of programs and services.

e. A plan for steps to be taken in meeting identified needs, including the rapid coordination and integration of services, the avoidance of unnecessary duplication and cost.

f. A plan for alternative funding strategies for meeting needs through the reallocation of existing resources, utilization of volunteers, contracting with local universities for services, and local government or private agency funding.

g. A description of barriers to the accomplishment of a comprehensive approach to the prevention of youth suicide.

h. Recommendations for changes that can be accomplished only at the state program level or by legislative action. The district local plan of action shall be submitted to the interprogram task force by October 1, 1985.

Section 10. It is the intent of the legislature that each school district develop a plan for providing student services to all students in the public school system, including area vocational-technical centers. Each school in a district shall submit a written student services plan to the superintendent and the school board annually. This school plan shall be jointly developed by the principal, staff members and school advisory committee. These plans shall be designed to ensure effective use of available resources and avoid unnecessary duplication. It is the intent of the legislature that student services coordinators be given time to fulfull their responsibilities under this section.

Section 11. A "student services program" is defined as a coordinated effort which shall include, but not be limited to:

(a) Guidance services, which shall include, but not be limited to, the availability of individual and group counseling to all students, orientation programs for new

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students at each level of education and for transferring students, consultation with parents, faculty, and out-of-school agencies concerning student problems and needs, utilization of student records and files, supervision of standardized testing and interpretation of results, the following up of early school dropouts and graduates, a school-initiated system of parental involvement, an organized system of informational resources on which to base educational and vocational decision making, and educational and job placement.

(b) Psychological services, which shall include, but not be limited to, evaluation of students with learning or adjustment problems, evaluation of students in exceptional-child education programs, consultation and counseling with parents, students, and school personnel, a system for the early identification of learning potential and factors which affect the child's educational performance, a system of liaison and referrals, with resources available outside of the school, and written policies which assure ethical procedures in psychological activities.

(c) Visiting teacher and school social work services, which shall include, but not be limited to, providing casework to assist in the prevention and remediation of problems of attendance, behavior, adjustment, and learning and serving as liaison between the home and school by making home visits and referring students and parents to appropriate school and community agencies for assistance.

(d) Occupational and placement services, which shall include, but not be limited to, the dissemination of career education information, placement services, and follow-up studies. Such follow-up studies may be conducted on a statistically valid random-sampling basis where appropriate and shall be stratified to reflect the appropriate vocational programs of students graduating from or leaving the public school system. The occupational and placement specialist shall serve as liaison between employers and the school. It shall be the responsibility of district placement personnel to make written recommendations to the superintendent for consideration by the district school board concerning areas of curriculum deficiency having an adverse effect on the employability of job candidates or progress in subsequent educational experiences. Further, district administrative personnel shall report to the school board concerning adjustments in program outcomes, curricula, and delivery of instruction as they are made with the use of placement and follow-up information.

(e) The distribution of a suicide prevention public awareness program developed for distribution by the interprogram task force established by the departments of health, education, rehabilitation and crippled children's service and mental health.

Section 12. Within two years after the effective date of this act and thereafter, each person who holds a certificate issued by the superintendent of education, provisional or otherwise, shall be required to demonstrate, on a comprehensive written examination, or through such other procedures as may be designated by the state board of education, mastery of the ability to recognize signs of severe emotional distress in students and techniques of crisis intervention with emphasis on suicide prevention and positive emotional guidance or development. The provisions of this section shall be construed in pari materia with Title 16, Chapter 23, Code of Alabama 1975, as amended, and other provisions of law related to teacher training and certification.

Section 13. The department of education shall include in the curriculum, for all students in either the ninth or tenth grade, credit for life management skills to include positive emotional development. The amount of credit shall be as assigned by the board. The provisions of this section shall be construed in pari materia with other provisions of law and lawful rules and regulations relating to student curricula for public schools, except where there is a direct conflict herewith.

Section 14. The provisions of this act are severable. If any part of the act is declared invalid or unconstitutional, such declaration shall not affect the part which remains.

Section 15. The provisions of this act shall be construed in pari materia with all laws or parts of laws relating to education, teachers, students, drug abuse, or suicide prevention; provided, however, that those laws or parts of laws which are in conflict herewith are hereby repealed.

Section 16. This act shall become effective immediately upon its passage and approval by the Governor, or upon its otherwise becoming a law.

411 Plantation Road
Perry, Florida 32347
May 6, 1985

Senator Arlen Specter, Chairman
Subcommittee on Juvenile Justice
Committee on the Judiciary
Hart-Senate Office Bldg., Rm. 331
Second and C Streets, N.E.
Washington, D.C. 20510

Dear Senator Specter:

I would like to submit the following testimony and the attached Chapter (4), "Parental Perspectives", from the State Plan: A Comprehensive Approach for the Prevention of Youth Suicide in Florida, to be included with the testimony presented last week at your hearings on teen suicide. Some of my special concerns have to do with the way teen suicide is being handled (and at times, sensationalized) through the media. In particular, I am concerned about the advisability of focusing a whole month's attention on youth suicide. I have worked for a year now on the Florida Task Force for Suicide Prevention with Health and Rehab. Services and D.O.E. personnel. I was a school teacher at the time of my son's death in 1982, at age sixteen. Since his death, I have devoted my time to research and prevention. I have also formed a network of parents who are survivors of suicide, and we have combined our efforts to help educate others and to offer assistance to other survivors. We have felt that, not only have we learned a great deal in the process, but that we have been able to help educate others by sharing our own experiences.

I would like to share with you a bit about our son who died. He was a fine young man; bright, he was in the top one/third of his class. He was a Volunteen in the local hospital, and shortly before his death, he was working in the school Guidance Office helping other young people with career counseling. The guidance counselor in that office was quoted as saying (to a reporter) that you never saw Doug "without a smile and a friendly greeting for everyone". That was just as true at home, and he brought much joy into our home those 16 years that he lived. Sadly, I did not hear about the devastating problems that happened to him at school until he was dead, though we communicated,and I knew something was wrong. He carefully masked his problem for two weeks, hoping, I guess, that things would improve.

His loss was mainly due to serious problems which impacted on him in his school environment due to violations by teachers of the Code of Ethics, plus very poor judgement on the part of the teachers. One caused an embarrassing incident to get entirely out-of-hand which caused Doug to lose face in front of his peers. He had always had good self-esteem. This, I have learned, can be quickly shattered in teens. In his depression over his problem, he heard another teacher, who I later learned dwelled uncommonly long on morbidity in the classroom, tell his class how they could "kill yourself, if you wanted to die 'painlessly'"..... by drowning yourself. Students shared this with me after his death in their own shock and pain. They also shared that they were tested on other morbid material, such as what drugs or poisons are used for "murder" or "suicide",and I now have the tests. The next night, after the lecture in which drowning was made to sound like a viable option, my son tied weights to his ankles and jumped into the deep end of our pool. Though the autopsy showed that he tried to get out, he was not able to, and his death was not "painless", as he choked to death. This teacher is no longer in the system, and "probable cause" was found to remove the one who caused the embarrassing incident at school.

When we received counseling along with our daughters, now ages 13 and 16, in order to be able to deal with the tragedy, I was urged by the Psychologist to take what happened to Doug to the Florida Senate in the hope that it would call attention to terrible problems in the school system and help others to avoid future tragedies. The psychologist was as shocked as we were that so many negative things could so impact on a young person in the school environment in a short period of time. I asked the Fl. Senate to find ways to enforce the Code of Ethics for Education, so that incompetent or sick teachers could be removed. I also asked that parents be notified whenever a teacher plans to deviate from his normal course of study and offer an unannounced course. (Parents now have some measure of protection,now that the Hatch Amendment has been enforced, however this doesn't cover all areas,as all are not Federally-funded.) I had, by the time I went to the Senate, talked with other parents whose children had school-related problems, and I also asked that research be begun to study the effect of constant negativity in the school environment on the minds of our youth. I wrote about some of these problems that others have experienced in the State Plan that is attached. Many are described in the book, CHILD ABUSE IN THE

CLASSROOM, which I enclosed. Through my research over the past 2½ years, I was aware of many of the problems before I read this book, and I related some of these to the Senators in 1983.

This year, the State of Florida began fingerprinting teachers who applied for positions in Florida, (see article enclosed which describes the number of teachers who had not reported criminal records of child molesting, etc.). Though this is some deterrent, it does nothing to check on teachers already in the classroom, and it does nothing to assure that the Code of Ethics will be enforced. Very often serious offenses are covered up to insure the image of the education system. This is very sad, but true.

Following my testimony, the Legislature did pass a bill for youth suicide prevention for Florida to be implemented in schools and in society. Naturally, I was very concerned about how the prevention programs would be implemented in the schools, and I felt strongly that whatever was offered to students must be kept very simple and brief and positive. I felt that it is important to let them know how to recognize when they or a friend need help and where to find that help --from parents or other resources such as clinics or clergy. I felt much more training was necessary for teachers and administrators to understand how to treat bereaved students returning after losses (this I learned from first-hand experience). I feel strongly that befriending programs that I learned about through talking with people in Plano could be very helpful for new or isolated students. As a teacher who understood the horrible drug problems so rampant in most schools even in early grades now, I realized that "suicide prevention" could take many forms, (one of these: "substance abuse prevention", - and a realization that the problem exists.) Though it was not a problem in my son's case, I feel that drug problems probably lead to many teen suicides or are a part of the problem in many cases. I felt very strongly that we must improve the school environment and provide healthy teachers and courses, if we were to truly have the "positive emotional development" and "self-esteem" that is a desired end. If the environment is not positive and healthy with teachers who are good role models, I knew that the products of these environments, the students, would not feel good about themselves or about their society. It was with all this in mind that I joined the Fl. Task Force for Prevention when I was invited. I feel that I have learned much from their input and I certainly hope that they have learned from my sharing. One thing that I have stressed is that it is just as important what one does NOT do for prevention, as what one DOES do, as this is a most sensitive issue and the students are very suggestible and impressionable. As Dr. David Shaffer has said, "Anytime you talk about teen suicide in the youthful community, you're walking on very thin ice."

I am pleased that we were able to come up with a Plan for prevention for Fl. that has been praised by Samuel Klagsbrun* on a visit as the best state comprehensive plan that he has seen. I should add that this plan required much coordination, research and effort over many months for all involved, but that it was accomplished with very little funding, as people who were already employed by HRS and the DOE were involved along with some experts in the field of Suicidology. My work and Dottie's was voluntary.

We have been most concerned by the role of the media in influencing the lives of our youth, and we feel, as many aggression researchers do, that it is a strong factor which contributes to youth suicide. We have also been concerned by the media coverage of the issue of teen suicide, particularly those sensationalized accounts graphically depicting teen suicide in the midst of what the CDC in Atlanta has deemed a "contagion" of teen suicide, and we worry about the effect on the cluster suicides. Many of us have seen, firsthand, the effects of suggestion on our own children in triggering suicide. We have also been appalled by the portrayals stereotyping parents of children who commit suicide as rich Hollywood types who are insensitive to the needs of their children. This is not only misleading to the public, but damaging to the survivors and their surviving children. I have not yet met a survivor that fits the mold depicted. I would like to say that of the ones I have grown to know and love, they are among the most devoted and caring people that I have ever met. They are also the ones who care the most that these horrible tragedies be reduced and that the true problems that are impacting on our youth be improved or changed where this is possible. We feel that, while some of the problems that children experience at home, such as losses through divorce or death or loss of friends through moves cannot be greatly diminished, we can teach parents how to better cope with children going through these changes. Most of all, we would like something to be done about the problem areas THAT CAN BE CHANGED: Schools, the media, and problems like drug abuse that affects our children in society. Problems in these areas can be recognized and parents can be made aware of the damage that is being done. After all, we cannot really be serious about prevention if we close our eyes to the daily onslaught of violence that children are exposed to on TV, even through MTV. We cannot ignore the possible damages done to the gifted children who become deeply involved in D&D in schools or in their public libraries as this "game" asks children to role-play violent roles such as murder, rape and torture. How in the world did this ever get into our schools anyway. There are a multitude of questions that we must seek answers to. There are hundreds of things that we can do that will be"suicide prevention" other than just dwelling on the topic of "suicide"in the classroom or through the media.

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*NOTE: Dr. Klagsbrun is the director of Four Winds Hospital in New York and has worked with suicidal youth for over 20 years.

We feel very strongly that the classroom must not be regarded as a place for clinical therapy. Sen. Samuel I. Hayakawa has stated that, "An educational heresy has flourished, a heresy that rejects the idea of education as the acquisition of knowledge and skills...the heresy of which I speak regards the fundamental task in education as therapy." As academics have been supplanted by non-academics, some of which have proved more harmful than helpful, the illiteracy rate has grown along with the despondency and despair in our youth. We must once again provide a healthy climate for learning and return to academics. This will help to reduce much of the stress and pressure felt by many who feel so inadequate in high school and in lower grades too. This return to excellence must be carefully phased-in so as not to create more stress, and the emphasis must be on quality--not quantity, as has often been the case.

While I feel that more press coverage on teen suicide will probably be more harmful than helpful, I feel that dialogue and sharing among responsible adults and young people is very helpful, as we can all offer insight to each other out of our own experiences. While I would not advise a month focusing on teen suicide in the media, I feel that a meeting of the minds could be helpful, and I would like to join with others who share the common goal of lowering the rate of teen suicide. I feel that positive programs are a real possibility, but I do feel strongly that these are best done on a State and local level, as each area understands best the needs of the people in each area of this country. Intervention methods are not a mystery and should be available to all. The hard part is doing something about the CAUSES. It will require of all of us to examine areas in the lives of our youth that many have never been concerned about before. Many of the problem areas are areas that we, as adults, have become desensitized to such as media violence, and many are areas that many people simply assume are still as they were when they themselves were children,such as the schools. This just isn't so, and awareness is the order of the day. Our children would not be self-destructing if they could withstand all that they are being exposed to, and the first step is to acknowledge that, and then to do what we can about it. I think we can gain some insight from reading the testimony of Julie Smith who testified before your Committee in October, 1984. She testified that she first learned about suicide from watching it on TV on a number of occasions. These are experiences that children were not exposed to 25 years ago when the suicide rate was 300% less than it is today.

I thank you for your interest in helping our youth and for hearing the testimony of those of us who endeavor to do what we can to prevent future deaths. May God grant us all the courage and wisdom to know the best way to approach this very sensitive issue, as well as the openess and willingness to share our feelings on the issue, even with those whose understanding is not the same as our own. May our youth eventually benefit from this sharing, and may we all learn from each other.

Very sincerely,

Gale D. Dickert

Gale D. Dickert

/gd
Enc.

EXCERPT FROM

A STATE PLAN
FOR
THE PREVENTION OF
YOUTH SUICIDE IN FLORIDA

CHAPTER 4

PARENTAL PERSPECTIVES

In its discussions, the Task Force recognized that survivors of suicide, who often suffer hurtful repercussions from society's misconceptions, can offer a unique, personal perspective on some of the problems of youth suicide. This chapter presents the testimony of two parent advocate Task Force members, concerning the problem of youth suicide and possible solutions. It is written from the vantage point of their experiences and research.

Gale Dickert and Dottie Katz, parents, submit the following recommendations based on our own experiences as survivors of suicide, work in the field of education, and based also on the growing concerns of parents we have talked with over the past two years.

It is our hope that Florida can be a leader in recognizing that "suicide prevention programs" cannot, alone, stem the accelerating tide of adolescent suicide. We must provide safe, healthy, positive environments in schools and in society for our youth and squarely face what some of the contributing factors are that could be changed, if recognized. If we provide "prevention services" without these needed changes, then we will be forced to watch the epidemic grow. It is not the children who are unwell, but the system.

In our haste to provide [illegible] programs for our youth, we taught them how to use drugs, in many cases, in school. We must listen to people like Dr. David Shaffer of Columbia University who tells us that anytime "we talk about suicide in the youthful community, we are walking on thin ice." We must, therefore, keep the training of the students simple, concise and brief. We suggest we use the word "crisis" intervention and prevention in describing to them where to seek help. May we also suggest here that the primary people to encourage students to seek help from be parents. For too long the schools have assumed to take over the roles of parents and these are some of the deepest concerns we have heard from parents. Parents must be notified when their children are having problems, are truant or are failing. This could save lives. If this isn't done; lives may be lost.

We recommend strongly that the curriculum that is to be developed along with manuals, brochures, etc. be in compliance with Florida Statutes, keeping in mind, in particular, the Protection of Pupil Rights Amendment, section 439 of the General Education Provisions Act (Hatch Amendment). Inspection should be made by parents or guardians of instructional materials, manuals, tapes, or any materials used in connection with prevention of suicide or the positive emotional development section of the Life Management Skills Course and other sections of this course. This law states that no student shall be required, as part of any applicable program, to submit to psychiatric examination, testing, or treatment, or psychological examination, testing or treatment, in which the primary purpose is to reveal information concerning the following:

(1) Political affiliations;
(2) Mental and psychological problems potentially embarrassing to the student or his family;
(3) Sex behavior and attitudes;
(4) Illegal, anti-social, self-incriminating and demeaning behavior;
(5) Critical appraisals of other individuals with whom respondents have close family relationships;
(6) Legally recognized privileged and analogus relationships such as those of lawyer, physicians, and ministers; or
(7) Income (other than that required by law to determine eligibility for participating in a program or for receiving financial assistance under such program).

Section (a) in its entirety states: "All instructional material, including teacher's manuals, films, tapes, or other supplementary instructional material which will be used in connection with any research or experimentation program or project shall be available for inspection by the parents or guardians of the children engaged in such program or project. For the purpose of this section "research or experimentation program or project" means any program or project in any applicable program designed to explore or develop new or unproven teaching methods or techniques." (This certainly applies to suicide prevention programs or the new Life Management Skills Course, and counseling programs devised to be used in conjunction with prevention programs.)

We recommend that the Life Management Skills Course not be expanded to a full year until it has been reviewed by parents and other concerned individuals.

In compliance with this law, we feel that testing such as "You and Death Survey" and any other tests devised to detect suicidal tendencies are unlawful. There have been suicides reported in connection with such questioning (one recent one reported in the Miami Herald Newspaper in October). If one life is lost due to such testing, we feel that it negates the whole reason for doing it in the first place. The same is, of course, true of testing in "death and dying" courses and life management courses that probe into the personal beliefs, attitudes, and personal problems of students. We believe that there are not now (and will not be for years) adequately trained personnel or trained teachers to deal with the disturbances stirred up by such questioning. Hundreds of parents, teachers and some counselors testified last March in many states before the U.S. Department of Education in protest to these invasions of privacy and breaking of the law. They are deeply concerned, as we are, about the anti-family values which they feel are being instilled into their children through values clarification courses, questionaires, and teaching in experimental government funded programs. We join with other parents in voicing our concerns and stating our beliefs that these are not preventive measures but could very well be contributing factors to suicide in youth. We are convinced that the process of decision-making, using values clarification techniques, undermines the authority of the parents and the home and causes students to become alienated, confused, rebellious to all authority and could lead them to become immoral (or amoral).

We feel that young people need structure, reinforcement of what is taught in the home, love and caring, traditional foundations of family and beliefs systems and a curriculum which reflects what parents want their children to be taught in school. We feel that teaching in its striving to be "neutral" in values and attitudes toward home and country and religion, tears at the very fabric of our American way of life and produces alienated, rootless, despondent, and fearful students. The burdening of students with the social issues which are most controversial today, such as abortion, nuclear war, and social conflicts that we ourselves find difficult to deal with, is prevalent in today's classrooms. This is done by schools which view their role as social change agents. We feel this, too, adds to pressures and is a contributing factor leading to hopelessness, despair, fear, and feelings of despair about the future --- and suicide in the young. Failure to adequately teach the basic skills of reading, writing and arithmetic in the early grades can lead to feelings of despair, futility and hopelessness in the teenage years. This can increase the feelings of stress and pressure in high school. It seems to us that more emphasis has been placed on changing the child's attitudes, feelings and values than on teaching the basic skills which would prepare him for life.

Two factors create more stress in both adults and young people than any others. They are LOSS (any kind, but particularly loss by death) and CHANGE. Loss can include loss of friends by moving or disagreements or romantic breakups for young people. It can be the death or divorce of a parent. A devastating kind of loss can be loss of face -- of self-esteem through being embarrassed, hurt by peers, teachers or parents, or through failing to make grades they expected of themselves. Loss can also stem from the loss of faith and trust one suffers when taught conflicting beliefs or values from those one learned to cherish in the home.

CHANGE has become a very important element in schools as they strive to promote social change swiftly and subtly through teaching the young new ideas about family roles, family systems, politics, sex, values, etc. When this directly conflicts with what is taught in the home, it creates confusion and STRESS and undue burdens children and youth cannot deal with. Often the conflicts created through such teaching causes strife and conflict in the home as the child tells the parents they no longer have control. He controls his own destiny, values and beliefs regarding family and country, sex, drugs, etc. More and more the schools have refused to communicate with parents and to hear their objections and suggestions. Parents have become wary and afraid to approach the schools for fear of being embarrassed, turned away or rejected. Senate Bill 529 calls for communication between parents and schools. It is our recommendation that ALL PREVENTION MATERIALS DEVELOPED FOR USE WITH STUDENTS BE PRINTED IN THE SAME FORM TO BE SENT OUT TO ALL PARENTS FOR THEM TO KEEP. WE REQUEST THAT FUNDING BE MADE AVAILABLE FOR THIS INFORMATION TO BE GIVEN TO EACH AND EVERY PARENT.

We further request that all parents must sign a form which describes each aspect of suicide prevention programs or life management skills programs to parents before their child is allowed to participate in such programs. This will help to begin the communication called for in the bill and will prevent unnecessary shock parents may experience who are not aware of what their children are being offered.

WE RECOMMEND THAT ALL TEACHERS WHO VIOLATE THE CODE OF ETHICS OF THE EDUCATION PROFESSION IN FLORIDA AND THE PRINCIPLES OF PROFESSIONAL CONDUCT FOR THE EDUCATION PROFESSION IN FLORIDA BE REMOVED FROM THE CLASSROOM, as we believe that child abuse in the classroom is a contributing factor to the hopelessness, depression and suicide of our youth in Florida. It has been pointed out that many criminals come to Florida to seek employment and, though the fingerprinting legislation has been passed, it will not insure that all teachers now employed will be safe teachers for our children. We feel that one large contributing factor leading to depression is the killing of self-esteem through embarrassment, harassment or neglect found in Florida's classroom(s), perpetrated not by those excellent teachers in the system, but by the unethical few who give the whole teaching profession a bad name. We tell you from experience that at times these teachers are not being removed when there is clear evidence that direct violations have occurred. Therefore, we urge the State Board of Education and the Education Commission to re-evaluate the goals and purposes of Professional Practices Services and the Education Standards Commission and that stricter guidelines be developed to insure that violators of the Code of Ethics, who endanger the health, safety, and emotional well-being of students, can be promptly removed from Florida classrooms. If we cannot do this---and strengthen the Code of Ethics against loopholes---it will greatly hinder efforts to prevent youth suicide in Florida. It must be recognized that the public school system has great influence over the lives of our youth.

WE RECOMMEND THAT THE FOLLOWING NEGATIVE ELEMENTS BE REMOVED FROM FLORIDA CLASSROOMS AS THESE HAVE PROVED, BY THE TESTIMONY OF COUNTLESS PARENTS, TO BE CONTRIBUTING FACTORS TO DESPAIR, DEPRESSION OR SUICIDE IN OUR YOUTH.

1. In recent textbook evaluations, we found that some companies have published books which are not predominantly negative, violent or anti-authority as many of the texts published in the 1960's and 1970's were. Therefore, we recommend that funds be made available (and evaluators - parents preferably) to examine texts that are excellent, will uphold parental values, be universally acceptable academically, and which will add to the child's own belief system, his love of parents and country and self and others. Many of the old textbooks which now fill our schools offer little positive to the child.

2. We recommend that the use of private and personal journals in the classroom which are examined in any way by teachers be abolished. This tool has led to atrocities being committed by teachers and students alike. Journals can be used by both students and teachers as a gossip tool and can invade the privacy of the student and his family. Too often, information is put in these which should go to a person who could help. Teachers are reluctant to get involved and this attitude, we fear, may not change. For this reason and many others, this practice, which most parents are not aware of, must be stopped. Many parents who are aware of this practice are incensed that this is allowed and encouraged.

3. We recommend that violent role-playing activities such as Dungeons and Dragons, that are often used in the classroom, particularly with our most gifted and sensitive students, be removed from Florida classrooms. It is our opinion that such games promote an interest in the occult and desensitize our youth to violent activity, since the games suggest playing violent roles. We base our opinion on incidences of youth suicide which were reportedly related to the youths' involvement in Dungeons and Dragons, and on statements of experts such as Dr. Arnold Goldstein, Ph.D., Director of The Center for Aggression Research, University of Syracuse. Recently, Dr. Goldstein stated: "I

think it is a bad idea to play a fantasy role-playing game such as Dungeons and Dragons. For many, such play causes subtle changes, which increase both a desensitization toward violence and a tendency to commit aggressive behavior. Dr. Radecki, Teaching Psychiatrist at the University of Illinois, released Dr. Goldstein's statement. Dr. Radecki, Chairman of The National Coalition on Television Violence stated that schools should teach children that violent entertainment, in general, such as violent movies, music or fantasy role-playing games is harmful and teaches anti-social behavior. The Surgeon General has reportedly warned us about the harmful effects of TV violence. Dr. Radecki further stated that he would estimate that between 25 to 50 percent of the murders committed in this country are directly related to violent entertainment.

We recommend that other violent role-playing be removed from the school setting such as those used in gifted programs that encourage students to role-play death, suicide, lying on a tombstone and imagining what it is like to be dead. Or role-playing violent acts, such as imagining that one is a bullet killing someone, which has been done in some schools for gifted programs in lower grades. Can you imagine disturbed children doing this -- and many, many children are disturbed in school today. Some are disturbed because of what they are required to do. Many parents have children come home from school in tears or in despair from what they have been exposed to.

It has become a common practice in the State of Florida and in other states for children to be required to write their own obituary. This is required also here in some schools in Leon County as a counselor mentioned in a suicide prevention workshop recently. In the book, Child Abuse in the Classroom, a parent gave the following testimony about a typical death and dying sequence in Colorado.

"We had an English course in the 7th grade junior high school......title was Death Education. In the manual, 73 out of 80 stories had to do with death, dying, killing, murder, suicide, and what you want written on your tombstone. One of the girls, a 9th grader, blew her brains out after having written a note on her front door that said what she wanted on her tombstone. Her young boyfriend, also in 9th grade, found her in that condition."

A young Haitian boy in Miami, who was being teased at school about being Haitian had to fill out the sentence ----- If I had a gun, I would _____________. He wrote in the blank, "If I had a gun, I would shoot myself." This was in values clarifications course in school. He went home that day, in early October 1984, and shot himself to death. (From Miami Herald).

These two examples point out how strongly influenced these children are by suggestion and how they will impulsively act out violent suggestion when depressed. My own son's case is another grim reminder that, not only do children express their depression in a different manner from adults, but that they also do not react to suggestions and questions and what they read in literature as adults do. Viewing movies where suicide is sensationalized, for example, may actually enhance its appeal to children.

IT IS OUR RECOMMENDATION THAT SCHOOL CURRICULA BE EXAMINED SO THAT THOSE ELEMENTS WHICH TEND TO UNDERMINE ALL PREVENTION PROGRAMS CAN BE REMOVED. This year there were new state texts, approved for the learning-disabled and for slow readers for grades 7-12, that offered what we believe to be incredibly terrible role models for the child, such as Cheech and Chong, rock groups like Cheap Trick, Pink Floyd and the Wall (who sing suicidal songs), Ted Nugent and others. This was a whole series of "Superstars" for the students to study for "reading comprehension" and to develop "vocabulary skills". There were also half-page pictures of these counter-culture influences so they could readily emulate them in their own behavior.)

We feel it is important that these points and realities be brought to the attention of the task force and to other parents as well, because it is ironic that we have teachers and counselors actively seeking information on how to prevent drug abuse and suicide (and other problems like teen pregnancy) and all the while they are offering materials that teach terrible role models, literature that we believe is anti-parent and anti-teacher and anti-life and that encourages drug consumption and suicidal behavior. Sex education courses have been taught that we feel are merely titillating and erotic to young students and offer abortion as an easy out. Teachers then may wonder why the poor girl got pregnant and is standing there feeling suicidal.

CLEARLY, we must make our own selves aware. We must first change ourselves and our schools. We must make ourselves aware that our children can't take all that we are exposing them to. Many are self-destructing. It is not their fault. It is ours. They can't change this society if we can't. If we burden them with all the problems of the world that we couldn't solve ourselves, they might just opt to decide not to grow up in this world that we make sound so grim. They might just decide they would be better off dead. Shouldn't our first examination begin with ourselves, our schools, and what we are offering them? Can't much of it be changed if we know it is damaging to their tender psyches?

WILL WE just seek to learn the signs and symptoms of suicidal depression and hope to catch them before the fatal bullet, or will we listen to countless parents who are crying out for changes in the media, in our schools and in society. We can't change it all, but we do at least have some control over what is offered in school, and we can speak out and make our voices heard about the media and society as the PTA is doing.

COULDN'T WE BE THE FIRST IN THE U.S., NOT ONLY TO HAVE A COMPREHENSIVE SUICIDE PREVENTION PLAN, BUT also to show that we really have the interest of our youth at heart by being willing to make real changes in ourselves, our views, our schools and our society. We can, if we realize that we are all reponsible for the lives of these children. If we don't make the necessary changes, they will continue to die needless, tragic deaths.

Despite the emphasis in classrooms on "Death and Dying", when a child experiences an actual loss and needs concerned teachers who understand what he's going through -- this is in most cases NOT AVAILABLE in school. These children return to school traumatized, unable to concentrate and extremely depressed. Special help and caring for children who've suffered losses (and who could be at risk of suicide) is one of the most needed assistances at school. This includes all loss related problems:

- death of loved ones
- loss of face through failed grades
- loss of a strong romantic tie
- loss of self concept or social status
- loss through divorce

These children don't need TESTING, programming, etc. They need a listening ear, caring teachers who don't demand perfection and who are patient, and a teacher who lets them go through their own grief process without undue demands from school. It's extremely important to let parents know when these students are absent or making poor grades -- indications of problems. Special allowances in grading and expectations for studies must be made and those students can be expected to be late or absent shortly after loss. Teachers must be trained so that abuses of bereaved students can be stopped.

In addition to changes that can be made in the school setting to provide a more healthy, positive environment, the concerned public needs to be made aware of the following societal factors which,in our opinion contribute to youth suicide:

- THE MEDIA: This includes MTV, TV violence and pornography. Teens see countless numbers of murders, rapes, mutilations, etc., on TV so that, by the time they are teenagers, they have become desensitized to violent acts. TV distorts the idea of death. It also makes teenagers feel that life situations should be solved in 30 minute segments as on the average TV show. It distorts reality. Shows such as The Day After create fearful feelings and terror in children, make them lose hope in tomorrow. For countless suicides, the final trigger has been after viewing a TV show or movie depicting suicide or violent behavior. I counted four I read about in newspapers after the graphic depiction of a hanging of a fine young man in An Officer and a Gentleman. This was over the course of one year. Britain is now taking action and protecting their youth from over-exposure to this kind of violent behavior.

- ADVERTISING: Encourages the disappearance of childhood; is anti-parent. Teens are encouraged by sports heroes to drink and smoke and have early sex, stressing very poor values and choices. Advertising has a tremendous influence over our youth.

- CULTURE is largely ANTI-CHILD and ANTI-PARENT. It encourages children to grow up quickly and rush at breakneck speed through life. INFORMATION is never-ending and absorbed quickly, but communication is not encouraged.

- Current interest in the OCCULT, cults and fantasy role-playing games (and their acceptance in schools in the last decade) we feel are a very negative feature in the lives of millions of our youth, and promote a very unhealthy interest in death, violence and the dark, negative side of life. It is unconscionable that this is promoted or even allowed in our school systems. There were two suicides police attributed to D&D in Lafayette, Colorado, this fall. Who knows how many suicides related to these practices go unreported as such? How many juvenile delinquents are we locking up who are involved actively in these pursuits? Police in some areas now routinely ask young offenders if they are involved in the games.

- ANTI-LIFE attitudes which have grown more pervasive over the past 20 years as the suicide rate has soared. Abortion has become merely a convenience and birth control method. Euthanasia is seeking a place in our society for the elderly and the ill. Pop-culture philosophers urge us to forego our guilt and abandon morals. Advocates of suicide like Hemlock are making their voices heard, and new manuals for suicide how-to are now on the market in some places.

- ROCK MUSIC urges through its lyrics for listeners to kill themselves (Pink Floyd and the Wall -- "Goodbye Cruel World") and school chorus groups have sung "Suicide is Painless", the theme song of MASH. School children read in their reading books and learn vocabulary while studying about Pink Floyd and the Wall's group, thus reinforcing the idea that this group's ideas have credibility in today's world to these innocent children.

- FEAR OF NUCLEAR WAR stemming from what children have heard from the media, parents, or classes using scare tactics in school, is in the back of the mind of every child. In a survey which asked students how they thought they would die, over 90% answered, "in a nuclear war." The very thought that such a survey would be done in school is frightening. The classes on war in school deserve much rethinking. We feel they are a terrible idea.

- DRUG AND ALCOHOL ABUSE — a shocking dilemma in most schools.

Dr. Shaffer is Chief of Child Psychiatry at Columbia University Psychiatric Unit and conducting a four-year study of adolescent suicide:

> Based on his studies of younger children, he thinks that "previously good" teenagers may kill themselves 'on impulse' after an episode of trouble"....My belief, though not yet confirmed, is that suicide is a catching, contagious behavior. Local epidemics may account for a significant number of adolescent suicides," says Shaffer, "And I think the more attention you give a suicide within the youthful community, the more you are on thin ice."

from Boston Globe article 1984

Dr. Mark Rosenberg of the Center for Disease Control in Atlanta and who is doing the other major study of teen suicide in this country made this remark on the Phil Donahue Show this year, in a conversation about causes of teen suicide:

> It seems this (teen suicide) has something in common with other infectious diseases. One is that like TB of yore, we end up blaming the victim and parents when it may have nothing to do with that. The second thing it has in common with these infectious diseases is that when there is one death in the community or in a high school, it may put other people in that community at risk.

Iris Bolton, Director of The Link Counseling Center in Atlanta, specialized in the area of suicidology at Emory University after the death of her son at age 20. She now lectures on the subject of teen suicide and has written a book on the subject. She testified in the hearings in Florida last winter on teen suicide. She has said:

> "People who kill themselves tend to be high achievers, perfectionists and sensitive people with a low tolerance for injustice. They also have an inability to communicate their hurts and have low self-esteem."

We hope these remarks help to dispel myths and misunderstandings....and also will help to prevent labeling certain children or families as suicidal. We think that would be extremely damaging. As you can see, it can be anyone or anyone's child. We certainly cannot hope to save them all. All we can do is learn preventive techniques and ways to intervene, always remembering that the first ones to notify for intervention should be the PARENTS with few exceptions.

Suggested reading: Child Abuse in the Classroom, testimony before the U.S. DOE.

The Disappearance of Childhood, Neil Postman

The Coming Parent Revolution, J. Westin

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